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A SUMMARY OF THE ACTIVITIES OF THE NORTH CAROLINA MEDICAL CARE COMMISSION 1947-1969

AND REPORTS FOR THE BIENNIUM 1967-1969

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REPORT OF
THE NORTH CAROLINA MEDICAL CARE COMMISSION

FOR THE BIENNIUM JULY 1, 1967 - JUNE 30, 1969

and

A SUMMARY OF ACTIVITIES
1947 - 1969

July 1, 1969

THE NORTH CAROLINA MEDICAL CARE COMMISSION
437 North Harrington Street
Raleigh, North Carolina

DEDICATION

The biennium saw two dedicated champions of improved health services retire after a long period of service as members of the Medical Care Commission.

Mr. Marshall I. Pickens represented The Duke Endowment on the Medical Care Commission from 1953 to June, 1969. He served as Vice-Chairman of the Commission from 1965.

Dr. Paul F. Whitaker was first appointed to the Commission in 1945 and served to 1946. He was reappointed in 1953 and served continuously from then to his retirement in June, 1969.

This report is dedicated to the timeless contributions these persons have made to the improvement of health services in North Carolina through their long years of service as members of the Medical Care Commission.

LETTER OF TRANSMITTAL

To His Excellency, ROBERT W. SCOTT
Governor of North Carolina
Raleigh, North Carolina

Sir:

The Medical Care Commission and Advisory Council present herewith the report of the activities of this department for the period July 1, 1967 — June 30, 1969, including selected summaries of information covering prior years to indicate the State's overall progress in developing medical facilities and programs since the inauguration of the Commission in 1945.

Respectfully submitted,

EDWIN N. BROWER, SR.
Chairman

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MEMBERS

THE NORTH CAROLINA MEDICAL CARE COMMISSION SERVING DURING THE BIENNIUM 1967 - 1969

Member	Address	Representation	Term Expiration
Mr. Edwin N. Brower, Sr. Chairman	Hope Mills	At Large	June 30, 1972
Mr. Marshall I. Pickens Vice-Chairman	Charlotte	The Duke Endowment	June 30, 1969
Dr. J. Street Brewer	Roseboro	N. C. Medical Society	June 30, 1969
Mr. Paul W. Bumbarger, Jr.	Hickory	At Large	June 30, 1972
Dr. George L. Carrington[1]	Burlington	At Large	June 30, 1967
Dr. H. Royster Chamblee[2]	Raleigh	At Large	June 30, 1967
Mr. J. B. Clemence	Salisbury	At Large	June 30, 1970
Mr. Eugene Cross, Jr.[3]	Marion	At Large	June 30, 1971
Mrs. Margaret B. Dolan	Chapel Hill	N. C. Nurses' Association	June 30, 1970
Dr. Powell G. Fox, Sr.	Raleigh	N. C. Medical Society	June 30, 1971
Mr. Ernest J. House[3]	Marion	At Large	June 30, 1967
Mr. Thomas R. Howerton	Wilson	N. C. Hospital Association	June 30, 1972
Dr. William D. James	Hamlet	At Large	June 30, 1969
Dr. Harold B. Kernodle[1]	Burlington	At Large	June 30, 1971
Dr. Henry O. Lineberger, Jr.[2]	Raleigh	At Large	June 30, 1971
Mr. H. C. McAllister	Chapel Hill	N. C. Pharmaceutical Assoc.	June 30, 1970
Dr. Hugh F. McManus, Jr.	Raleigh	N. C. Medical Society	June 30, 1970
Dr. William Raney Stanford	Durham	At Large	June 30, 1972
Mr. John C. Whitaker	Winston-Salem	At Large	June 30, 1969
Dr. Paul F. Whitaker	Kinston	At Large	June 30, 1969
Mr. Carl P. Worley, Jr.	Selma	At Large	June 30, 1969
EX-OFFICIO MEMBERS			
Mr. Clifton M. Craig	Raleigh	State Commissioner of Social Services	
Dr. Jacob Koomen	Raleigh	State Health Director	

1 Dr. Harold B. Kernodle succeeded Dr. George L. Carrington
2 Dr. Henry O. Lineberger, Jr. succeeded Dr. H. Royster Chamblee.
3 Mr. Eugene Cross, Jr. succeeded Mr. Ernest J. House.

MEMBERS
STATE ADVISORY COUNCIL

Serving During the Biennium 1967-1969

Member	Address	Term Expiration
Dr. W. T. Armstrong	Rocky Mount	June 30, 1969
Mr. Charles R. Cannon	Concord	June 30, 1969
Dr. W. Ralph Deaton, Jr.	Greensboro	June 30, 1969
Mrs. Carrie T. Phelps	Creswell	June 30, 1969
Mr. James P. Richardson	Charlotte	June 30, 1969

ADMINISTRATIVE STAFF

June 30, 1969

Name	Position
William F. Henderson	Executive Secretary
I. O. Wilkerson, Jr.	Assistant Executive Secretary
O. Wade Avant, Jr.	Hospital Consultant
Ruth W. Hathaway	Administrative Officer
Bruce K. Jones	Consulting Architect
Ray F. Lefler	Hospital Consultant
Mrs. Elizabeth S. Mason	Hospital Nursing Consultant
Duncan L. McGoogan	Hospital Consultant
Anne M. Parker	Social Research Assistant
A. C. Penny	Business Officer
Mrs. Janet M. Proctor	Administrative Officer
C. W. Sanders, Jr.	Hospital Consultant
Raymond C. Sawyer	Consulting Architect
John W. Sherman	Consulting Engineer
June Sherrill	Medical Records Librarian
Conrad M. Taylor	Consulting Architect
Donald M. Watson	Consulting Engineer
Lucille Weatherman	Hospital Nursing Consultant

SECRETARIAL STAFF

Mrs. Sue M. Jones
Mrs. Emogene K. Massey
Mrs. Lynda W. Milam
Mrs. Elsie C. Olmstead
Mrs. Linda R. Parker
Mrs. Carolyn F. Sutton

BACKGROUND AND GOALS

It was the intent of the legislation creating the Medical Care Commission in 1945 (General Statutes Chapter 131, Article 13 and 13A) to set up a state agency to specialize in the planning, financing and construction of medical facilities throughout North Carolina and in the standardization of hospitals particularly, and to study ways and means of staffing the State's expanding medical programs.

Through the years, the Commission has developed a close relationship with the State's community hospitals and is thought of as the agency technically staffed and oriented to advise with hospitals on their specialized requirements.

The Commission is composed of twenty members. Three are nominated by the State Medical Society, one by the State Pharmaceutical Association, one by the North Carolina Nurses' Association, one by the State Hospital Association and one by The Duke Endowment. These nominations are subject to the approval of the Governor. In addition, eleven members, one of which by law must be a dentist, are appointed by the Governor directly so as to fairly represent agriculture, industry, labor and other appropriate consumer interests and groups in North Carolina. The State Health Director and the State Commissioner of Social Services are ex-officio members. The Commission regularly meets each quarter and additional meetings are held when necessary.

Pursuant to Federal requirements, the Governor appoints a State Advisory Council composed of five members to advise with the Commission on technical matters relating especially to the planning and construction of medical facilities. The Council meets regularly with the Commission.

During the biennium, the responsibilities of the Commission were divided into three major programs:

A. Planning and construction of hospitals, public health centers, diagnostic and treatment facilities for ambulatory patients, long-term chronic and convalescent extended care facilities including nursing homes and rehabilitation facilities.

   Toward the end of 1965, under the auspices of Public Law 88-164, the Medical Care Commission was designated by the Governor to develop in cooperation with the State Department of Mental Health, the North Carolina Mental Health Council and the North Carolina Council on Mental Retardation a statewide plan for the construction of community mental health centers and facilities for the mentally retarded.

B. Licensing of hospitals. The staff of this section also provides consultation services to assist hospitals in participating in the Medicare program.

C. Loans to students enrolled in accredited programs of training in the health-related professions.

RECENT LEGISLATION

Legislation passed by the General Assembly of 1969 affecting the Commission's programs provided a continuation of the administrative budget to support the programs on levels prevailing for the prior biennium. Appropriations were made for State supplementation in medical facility construction projects eligible to receive Federal grants under the Hill-Burton program, as shown in Table III-B. This appropriation authorized sums as needed for the construction of facilities for the mentally retarded as well as for hospitals, extended care facilities and public health centers. In a separate appropriation, $600,000 were made available to the Commission as State aid for the construction of community mental health centers. To continue the student loan program, $600,000 were appropriated to finance scholarships for new students during the two-year period.

Other primary legislation passed by the 1969 session of the legislature affecting the health field is summarized below:

Doctor Shortage and Medical Schools
(as summarized by the Institute of Government)

The report of the Legislative Research Commission on its study of the physician shortage included a number of recommendations which were acted upon. Recognizing the critical need for more health manpower input, resolutions were passed which (a) urged the Boards of Education and Higher Education actively to pursue the strengthening of science and other facets of *premedical education* in schools (Res. 103, S 200), (b) asked the medical societies, guidance counselors, and others to promote interest in *medical careers* (Res. 43, S 198), (c) requested all three medical schools to increase their *output of practicing physicians* by increasing the classes, accelerating the educational process, and orienting medical education toward practice (Res. 104, S 199), and (d) directed the 1969-71 Legislative Research Commission to make a broad *study of health manpower* supply and distribution problems and potential solutions, including changes in the health care system (Res. 55, H 306).

The Commission report generated considerable discussion about the needs of medical schools, resulting in the restoration of $10 million in capital appropriations for preclinical, clinical, and hospital facilities needed at Chapel Hill to expand the medical school classes to 100 or more. Also for the UNC medical school, $400,000 was given to new programs for special teaching of North Carolina medical students and teaching of out-patient or ambulatory care (Ch. 1107, H 300), and for training physicians for family and community medicine (Ch. 1108, H 307).

The focus on medical schools brought about two other important developments. There was a special appropriation (Ch. 1273, H 653) for grants to the Duke and Bowman Gray medical schools based on

$2500 for each North Carolina student, provided that the school increases the number of entering North Carolina students each year. A stated purpose of that act is to encourage the schools to orient students toward personal health care in the state and to foster family and community medicine, but the grant is tied only to the residence factor. Another special appropriation of $375,000 (Ch. 1189, H 1199) is to be used for planning and developing a two-year curriculum for a medical school at East Carolina University; this act revived the 1965 legislation (G.S. 116-46.4) authorizing a medical school upon certain conditions which had not been met.

Other

Ch. 1138, H 278 doubled State aid to diploma nursing schools from $100 to $200 per student.

Ch. 612, H 468; Ch 929, H 1274 changed the medical license law authorizing graduates of osteopathic colleges approved by the American Osteopathic Association to take the examination for full medical licensure.

Ch. 556, S 500 rewrote the Physical Therapy Practice Act to require a license for the practice of physical therapy and physical therapy assistants.

Ch. 843, S 642 makes mandatory the licensing of nursing home administrators for facilities qualifying for Federal medical assistance.

Res. 116, S 739 directed the Legislative Research Commission to study the possible licensing of commercial donor blood banks and related laboratory personnel.

Ch. 1119, S 717 authorized local governing bodies to donate hospital property to nonprofit corporations even when the property was acquired and constructed from previous bond sale proceeds.

Ch. 1040, S 806 provided for the implementation of Title XIX of the Social Security Act in North Carolina effective January 1, 1970 furnishing medical assistance for certain public assistance recipients and medically indigent.

Ch. 1219, S 842 authorized the Medical Care Commission to use a part of its appropriations for student loans for recruiting health personnel.

Ch. 1069, S 815 permits the Medical Care Commission to change interest rates for student loans at its discretion rather than having the rate established by law.

PART I

Planning and Construction of Medical Facilities

The development of medical facilities during the two-year period underwent changes about as dramatic as any witnessed during the almost twenty-five year history of the Medical Care Commission. Inflation, more than usual, took its toll in construction costs. The newly inaugurated Federal Health Insurance Program for the Aged (Medicare) made sweeping changes in hospital use patterns. These influences are examined below:

Additional Beds

During 1967, 440 new hospital beds were added to the State's community hospital system; 186 additional beds were contracted as expansion of existing facilities. In 1968, 442 new beds were placed under contract; 306 were inaugurated as additional units of existing facilities. The scope of this expansion follows somewhat the typical annual pattern except that 1968 witnessed considerably more beds being added than for the average prior year.

Building Area Changes

The most dramatic physical change occurred in the square foot areas required per bed in expansion projects. As an example, in 1967 the square foot per bed for all-new hospital construction averaged 693 square feet; whereas, for beds added to existing structures, the average per bed was 1,000 square feet. This increased to 834 and 1,479 square feet, respectively, through the first six months of 1969, which marked the end of the biennium.

Increased Building Costs

In order to show the sweeping changes costwise, a better perspective can be gained by looking at the increased costs from the period 1964 to the end of fiscal 1969: The average total project cost per square foot for this period for all-new hospitals increased 40.7%; for expansion projects 58.3%. *When computed on a per-bed cost, all-new construction increased 78.7%; expansion projects increased 191%.*

The Associated General Contractors reported that general construction costs across the nation (based on 20 major cities) increased 21.3% from 1964 through mid-1969 and that general construction costs for North Carolina during the same period rose 31.7% as compared with 28.9% increase for Medical Care Commission projects.

The above comparisons dramatize the tremendous sums of additional capital that is needed for hospital construction now as compared to prior periods. Not all of this increase, however, can be attributed to inflation. Much of it is to accommodate additional space that is demanded by the ever-increasing sophistication of hospital services.

Medicare's Impact

The influence of the newly inaugurated Medicare program (July, 1965) while not unexpected has changed hospital usage in important proportions. Between 1965 and 1967, total patient days in North Carolina provided in general hospitals increased only 4% while discharges decreased almost 6%. Patient days for the 65-and-over group covered by Medicare, however, increased 50% and at the same time, discharges for the elderly group increased 28%. Other interesting comparative statistics are summarized below:

	1965	1967	
Percent days 65+	20.3	29.3	
Percent discharges 65+	11.9	16.1	
Average stay 65+	11.9	13.5	
Average stay all patients	7.2	7.4	
Average percent occupancy (total)	74.7	75.4	
General beds	17,425	17,955	- 3% increase

Some hospitals, especially those in the more rural communities, reported the percentage of days of care by the elderly as being as high as 77.5%; many running over 50%. These statistics say, or seem to say, that North Carolina hospitals are admitting fewer total patients and fewer patients under 65; that Medicare is affecting hospital admissions for the aged; that one is tempted to speculate would hospital occupancy have dropped without Medicare. No one seemed to think that it would have. However, these statistics appear to report that there is a growing percentage of patients in general hospitals that are inappropriately retained for lack of alternative facilities and that as a result many of our hospitals are ceasing to be general in nature, but are providing more and more long-term care services for a smaller segment of the population.

Other Approaches?

These observations point up the need for the Commission to study more intensively a redirection in emphasis on hospital building and incentives to encourage local sponsorship of alternate accommodations for the long-term care patient as well as the ambulatory patient.

Measuring Need

Federal criteria prescribed for determining general and long-term care bed needs and the mechanics of accommodating these criteria by counties in the State Plan for construction changed substantially with the adoption of amendments to the Hill-Burton Act. The beds-to-population ratio has been replaced by a new "use-rate"-population method. The new method involves (1) establishment of hospital service areas related to medical trade areas but not necessarily the geographical boundaries of a political subdivision; (2) estimate of the current and projected population; (3) determination of the number of patient days of care per 1,000 population per year required to accommodate the service area; (4) a 5-year projected average daily census; (5) adjustment of the average daily census to allow for 80% occupancy of the facility; and (6) estimated bed need as determined by subtraction of existing beds from projected total bed need.

Some of the difficulties encountered in applying the new method have been: (1) A small hospital experiencing an 80% occupancy but in effect being utilized to the maximum extent because of physical limitations will not demonstrate a need for additional beds. (2) The formula does not recognize the fact that need and demand for hospitalization increases disproportionately with population. (3) Inability to precisely match the population of a service area and patient days of care within the area causes the calculation of bed need to be more speculative than desired and difficult to apply to individual facilities.

Long-Term Care in the General Hospital

It can be concluded from the above experience that there is a great need for long-term care beds, perhaps greater than for acute facilities. The Medical Care Commission has encouraged hospital sponsors to develop extended care facilities as substitutes for some of the acute beds, the need for which may be more implied than precise. Table VI shows that at the end of the biennium 577 extended care beds were under construction as units of general hospitals, involving a total cost of over $10 million. Table VII shows, as of the same time, 91 extended care beds were in planning but had not reached the bidding stage. The estimated cost for two projects providing these beds is $1,331,000.

While something over 1,500 long-term care beds have been programmed under Hill-Burton, not nearly all of those have been used for this purpose after their activation. This phenomenon is probably the result of the general absence of pre-payment insurance programs designed to cover the cost of care of patients in extended care institutions. Statistics show that people using these facilities stay for long lengths of time — over 12 months. Medicare, and other insurance mechanisms generally, do not provide for coverage of patients for long stays. Very probably until an insurance program can be devised to insure patients against long and costly illnesses in extended care facilities, there will be no great demand for the development of these buildings as units of general hospitals.

Project Economy — Cost Controls

The alarming acceleration in hospital building costs during the biennium, to which earlier reference was made, prompted the Commission to establish from its membership a Project Construction Committee and clothe it with the specific assignment to investigate causes of increased construction costs and to formulate recommendations to effect economies that would not jeopardize functional usefulness of medical structures. The committee, chairmaned by Mr. Carl Worley, Jr., summarized its findings at the Commission's annual meeting on June 20, 1969 as follows:

> Costs have increased 30% in the last four years and during the last 12-month period, they rose 15% for all-new construction and 20% for projects involving alterations and additions. During the period, bids for 10 projects exceeded original estimates by a total of $2,250,000. Many projects use matching funds derived from local bond issues. Since the recent increases in the prime interest rates, bond yields have increased for "A" rated counties to almost 6% and the Local Government Commission advises that counties with less than "A" may have difficulty in selling their bonds at any interest rate the counties can afford. It is questionable that several counties

which have already passed hospital bond issues can sell their bonds at a rate the economy of the county can afford.

Bills are in Congress that will substantially change Hill-Burton from a grant to a loan program. This will mean that hospitals will have to borrow money and the amortization of the loans must fall heavily upon patients, resulting in increased hospital bills. For all these reasons, the Commission must examine more closely factors increasing hospital construction costs. The committee expressed the opinion that the Commission has an obligation to the public to review projects critically and to insist that before its participation is approved unnecessary embellishments and inefficiencies be pruned from the plans.

As an experiment, the committee and the Commission's staff, working closely with The Duke Endowment, suggested several prospective projects in the planning stage to engage the services of a value engineering or cost reduction consultant. A firm was interviewed for four potential projects which agreed to use the service. In order to determine if the consultant is able to cut unnecessary costs from projects, The Duke Endowment agreed to pay half of his fee if the individual hospitals would pay half. The Commission will be able to decide at bid openings for these experimental projects if this procedure has valuable application to other projects.

The committee concluded:

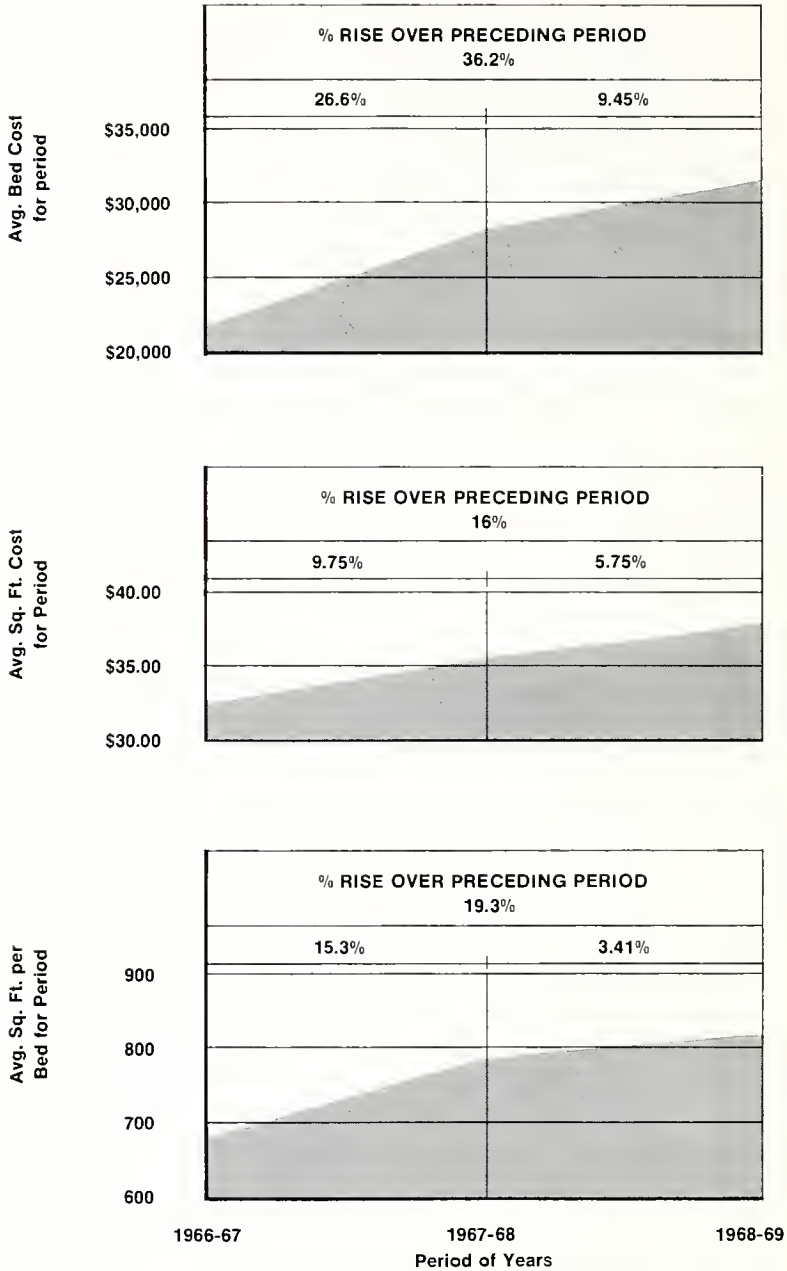
1. While inflation and changes occurring in architectural design and equipment to accommodate ever-increasing clinical demands make certain project costs uncontrollable, it is obvious to the committee that there are instances when costs can be controlled at no detriment to project function and efficiency.
2. The Medical Care Commission as trustee of vast public funds has both a legal and moral responsibility to demand in exchange for its grants practical economies that do not compromise need and function. At the same time, the Commission is obligated to define as much as possible unnecessary costs and to restrict the scope of projects and their costs, when necessary, to effect desirable economies and to deploy funds equitably in all sections of the State.
3. Because the volume of needs exceeds resources available, the Commission should decline participation in projects or segments of projects that exceed documented need and reasonable costs.

As steps in effecting economies, the committee recommends the following be adopted as official policy and procedure of the Medical Care Commission:

1. Establish guidelines for defining ineligible costs and for aiding sponsors in eliminating inefficient planning and unjustifiable embellishments.
2. Require completed working drawings and specifications to accompany preliminary applications and commitment of Federal and State funds on the basis of approvable finished plans rather than on schematic drawings as is the present practice.

3. Suggest one or two projects on an experimental basis to use a cost control consultant to determine the value of this service in eliminating unnecessary costs in project construction plans.
4. Caution prospective applicants during the development of their plans that priority will be given to project plans that more nearly conform to the spirit and intent of the Commission's guides for promoting economy and project efficiency and that the Commission reserves the right to decline participation in projects which, in its opinion, cannot be justified on the basis of excessive costs attributed to uneconomical and inefficient planning.
5. Disseminate more publicity to boards of trustees and boards of county commissioners concerned with specific projects as to Commission comments on elements contributing to excessive costs as observed from the review of project plans.
6. Continue the Project Construction Committee as a permanent committee and its membership be rotated periodically to provide for wide participation by Commission membership.

Statistics summarizing the construction activities are carried in the tables that follow.



TRENDS IN COSTS* OF ALL-NEW GENERAL HOSPITAL PROJECTS DEVELOPED UNDER THE HILL-BURTON PROGRAM IN NORTH CAROLINA 1966-1969

*total project costs excluding site costs

TABLE I-A

Data on Projects Approved During the Fiscal Year
July 1, 1967 - June 30, 1968

Project Address	Type	Beds	Total Cost	Federal Share	State Share	Local Share
Caswell County Health Center Yanceyville	(N) Health Center		89,135 00	49,024.25	-0-	40,110.75
City Memorial Hospital Thomasville	(N) Hospital	150(G)	3,545,454 54	1,950,000.00*	100,000.00	1,495,454 54
Ashe County Memorial Hospital Jefferson	(N) Hospital	75(G)	1,941,000.00	443,182.00[1] 975,000.00	100,000.00	422,818 00
District Memorial Hospital of Southwestern North Carolina Andrews	(A) Hospital	30(G)	1,499,360.00	271,668.00[1] 817,668.50	100,000.00	310,023.50
High Point Memorial Hospital High Point	(A) Hospital	118(G)	3,636,363.63	2,000,000.00*	-0-	1,636,363.63
C. J. Harris Community Hospital Sylva	(A) Hospital	30(G)	1,628,397 00	307,099.00[1] 895,618 35	100,000.00	325,679 65
Lenoir County Hospital Kinston	(N) Hospital	280(G)	5,454,545.45	3,000,000.00*	100,000.00	2,354,545.45
Rutherford Hospital Rutherfordton	(A) Hospital	61(G)	2,727,272 73	1,500,000.00	100,000.00	1,127,272.73
Irene Wortham Day Care Center for Mentally Retarded Asheville	(N) Mental Retard		213,330.00	132,264 60	49,065.90	31,999.50
Developmental Evaluation Clinic and Day Care Center for Mentally Retarded Greenville	(N) Mental Retard		239,290.00	148,359.80	-0-	90,930.20[2]

TABLE I-A (Continued)

Data on Projects Approved During the Fiscal Year
July 1, 1967 - June 30, 1968

Project Address		Type	Beds	Total Cost	Federal Share	State Share	Local Share
Gaston Children's Center for Mentally Retarded Gastonia	(N)	Mental Retard.		381,240.00	236,368.80	87,685.20	57,186.00
Charlotte Rehabilitation Hospital Charlotte	(A)	Rehab.	A/C & S/F	208,050.00	128,991.00	-0-	79,059.00
Harnett County Mental Health Center Buie's Creek	(N)	Mental Health		202,300.00	125,426.00	46,529.00	30,345.00
Lee County Mental Health Center Sanford	(N)	Mental Health		233,000.00	144,460.00	53,590.00	34,950.00
Johnston County Mental Health Center Smithfield	(A)	Hospital	20(Psy.)	770,000.00	477,400.00	100,000.00	192,600.00
Mecklenburg Center for Human Development Charlotte	(N)	Mental Retard.		341,000.00	211,420.00	-0-	75,020.00[2] 54,560.00
Total 1967-1968	16	Projects	744(G) 20(Psy.) 764	23,109,738.35	13,813,950.30	936,870.10	8,358,917.95

* Although committed to project, did not come out of one year's allotment
1 Special funds provided under Appalachian Regional Development Act
2 Direct State appropriations
A - Addition to existing facility
N - All-new facility
G - General beds
Psy - Psychiatric beds
A/C & S/F - Air conditioning and service facilities

TABLE I-B

Data on Projects Approved During Fiscal Year
July 1, 1968 - June 30, 1969

Project Address		Type	Beds	Total Cost	Federal Share	State Share	Local Share
Gaston County Hospital Gastonia	(N)	Hospital	400(G)	15,000,000.00	2,000,000.00*	108,000.00	12,892,000.00
North Carolina Baptist Hospital Winston-Salem	(A)	Hospital	176(G) 176(LTC)	18,225,872.00	2,000,000.00*	-0-	16,225,872.00
Chowan County Hospital Edenton	(N)	Hospital	60(G)	1,500,000.00	600,000.00	108,000.00	792,000.00
Northwestern District Hospital of Halifax County Roanoke Rapids	(N)	Hospital	150(G)	3,750,000.00	1,500,000.00*	108,000.00	2,142,000.00
Martin County Hospital Williamston	(N)	Hospital	50(G)	1,250,000.00	500,000.00	108,000.00	642,000.00
Montgomery Memorial Hospital Troy	(A)	Hospital	14(G)	1,692,876.00	677,150.00	108,000.00	907,726.00
Polk County Hospital Tryon	(N)	Hospital	66(G)	1,650,000.00	660,000.00	19,800.00	970,200.00
Iredell Memorial Hospital Statesville	(A)	Hospital	82(G)	3,216,421.00	1,286,568.00*	108,000.00	1,821,853.00
Wilson Memorial Hospital Wilson	(A)	Hospital	78(LTC)	1,274,566.00	509,826.00	108,000.00	656,740.00
North Carolina Lutheran Home Albemarle	(N)	Nursing Home	50(LTC)	683,000.00	273,200.00	52,591.00	357,209.00
Buncombe County Health Center Asheville	(N)	Health Center		750,000.00	300,000.00	-0-	450,000.00
Memorial Mission Hospital Asheville	(A)	Hospital	25(G)	2,496,828.00	71,172.00	-0-	2,425,656.00
Asheville Orthopedic Hospital Asheville	(A)	Hospital	24(Rehab.)	830,030.00	135,000.00[1] 514,618.60	-0-	180,411.40
Blue Ridge Mental Health Center Asheville	(N)	Mental Health		333,333.00	206,666.00	76,667.00	50,000.00

TABLE I-B (Continued)

Data on Projects Approved During Fiscal Year
July 1, 1968 - June 30, 1969

Project Address		Type	Beds	Total Cost	Federal Share	State Share	Local Share
Guilford County Mental Retardation Complex Greensboro	(N)	Mental Retard.		542,480.00	336,338.00	-0-	124,770.00[2] 81,372.00
D. E. C. of Duke-Civitan Center for Research on Mental Retardation and Child Development Durham	(A)	Mental Retard.		572,467.00	102,184.00	37,907.00	432,376.00
Edgecombe Comprehensive Mental Health Treatment Center Tarboro	(N)	Mental Health		400,000.00	248,000.00	92,000.00	60,000.00
Total 1968-1969	17	Projects	1,023(G) 304(LTC) 24(Rehab.) 1,351	54,167,873.00	11,920,722.60	1,034,965.00	41,212,185.40
Total for Biennium	33	Projects	1,767(G) 304(LTC) 24(Rehab.) 20(Psy.) 2,115	77,277,611.35	25,734,672.90	1,971,835.10	49,571,103.35

* Although committed to project, did not come out of one year's allotment
1 Special funds provided under Appalachian Regional Development Act
2 Direct State appropriations

A - Addition to existing facility
N - All-new facility
G - General beds
LTC - Chronic disease and nursing home beds
Rehab - Rehabilitation beds

TABLE II-A

Data on Projects for Which Bids Were Taken During the Fiscal Year
July 1, 1967 - June 30, 1968

Name of Project	New or Addition	Number of Beds	County	Total Cost	Federal Share	State Share	Local Share
General Hospitals							
Chatham Hospital	A	S/F	Chatham	422,833.16	181,725.00	-0-	241,108.16
Duplin General Hospital	A	50	Duplin	2,357,852.90	906,000.00	-0-	1,451,852.90
Edgecombe General Hospital	A	16	Edgecombe	955,000.00	525,250.00	-0-	429,750.00
Nash County Hospital	N	292	Nash	8,209,129.00	2,000,000.00	-0-	6,209,129.00
Wilkes General Hospital	A	30	Wilkes	1,049,039.12	689,400.00	-0-	359,639.12
Subtotal 5 Projects		372		12,993,854.18	4,302,375.00	-0-	8,691,479.18
Long-Term Care Facilities							
Chatham Hospital	A	30	Chatham	519,618.04	224,829.00	16,974.00	277,815.04
Edgecombe General Hospital	A	36	Edgecombe	600,000.00	330,000.00	-0-	270,000.00
Mountain Sanitarium and Hospital	A	50	Henderson	884,300.00	480,000.00	25,200.00	379,100.00
Wilkes General Hospital	A	30	Wilkes	600,000.00	330,000.00	-0-	270,000.00
Subtotal 4 Projects		146		2,603,918.04	1,364,829.00	42,174.00	1,196,915.04
Rehabilitation Facilities							
Duke University Medical Center	A		Durham	1,036,176.00	612,059.00	-0-	424,117.00
Mental Health Centers							
Western Carolina University Mental Health Center	N		Jackson	256,609.34	184,246.70	-0-	72,362.64
Southern General Hospital Mental Health Center	A	25	Robeson	563,847.71	346,500.00	50,000.00	167,347.71
Subtotal 2 Projects		25		820,457.05	530,746.70	50,000.00	239,710.35

TABLE II-A (Continued)

Data on Projects for Which Bids Were Taken During the Fiscal Year
July 1, 1967 - June 30, 1968

Name of Project	New or Addition	Number of Beds	County	Total Cost	Federal Share	State Share	Local Share
Facilities for the Mentally Retarded							
Facility for the Mentally Retarded at Butner	N		Granville	504,054.00	317,554.00	-0-	186,500.00
Western Carolina University Facility for the Mentally Retarded	N		Jackson	323,158.66	218,007.14	-0-	105,151.52
East Carolina University Sheltered Workshop and Vocational Rehabilitation Center	N	_	Pitt	284,705.71	179,364.60	50,000.00	55,341.11
Subtotal 3 Projects				1,111,918.37	714,925.74	50,000.00	346,992.63
Total 15 Projects		543		18,566,323.64	7,524,935.44	142,174.00	10,899,214.20

S/F - Service facilities only

TABLE II-B

Data on Projects for Which Bids Were Taken During the Fiscal Year
July 1, 1968 - June 30, 1969

Name of Project	New or Addition	Number of Beds	County	Total Cost	Federal Share	State Share	Local Share
General Hospitals							
Ashe County Memorial Hospital	N	76	Ashe	2,619,468.97	568,182.00[1] 975,000.00	100,000.00	976,286.97
Memorial Mission Hospital	A	25	Buncombe	2,496,828.00	71,172.00	-0-	2,425,656.00
District Memorial Hospital of Southwestern North Carolina	A	30	Cherokee	1,638,139.00	271,668.00[1] 817,668.50	100,000.00	448,802.50
Chowan County Hospital	N	60	Chowan	1,886,935.39	600,000.00	108,000.00	1,178,935.39
City Memorial Hospital	N	150	Davidson	3,855,294.00	1,950,000.00	100,000.00	1,805,294.00
North Carolina Baptist Hospital[2]	A	36	Forsyth	14,083,000.12	-0-	-0-	14,083,000.12
High Point Memorial Hospital	A	119	Guilford	4,834,080.00	2,000,000.00	-0-	2,834,080.00
C. J. Harris Community Hospital	A	31	Jackson	1,639,286.06	307,099.00[1] 895,618.35	100,000.00	336,568.71
Lenoir Memorial Hospital	N	285	Lenoir	9,259,625.50	1,584,000.00	100,000.00	7,575,625.50
Montgomery Memorial Hospital	A	32	Montgomery	1,855,497.66	677,150.00 400,000.00[1]	108,000.00	1,070,347.66
Rutherford Hospital	A	70	Rutherford	4,587,893.70	1,500,000.00	100,000.00	2,587,893.70
Subtotal 11 Projects		914		48,756,048.40	12,617,557.85	816,000.00	35,322,490.55
Long-Term Care Facilities							
North Carolina Baptist Hospital	A	176	Forsyth	2,753,728.46	1,000,000.00	-0-	1,753,728.46
Rehabilitation Facilities							
Charlotte Rehabilitation Hospital	A	A/C	Mecklenburg	279,783.45	128,991.00	-0-	150,792.45
Public Health Centers							
Buncombe County Health Center	N		Buncombe	2,505,136.32	300,000.00	-0-	2,205,136.32
Caswell County Health Center	N		Caswell	133,585.66	49,024.25	37,804.74	46,756.67
Onslow County Health Center	N		Onslow	145,982.53	72,600.00	-0-	73,382.53
Subtotal 3 Projects				2,784,704.51	421,624.25	37,804.74	2,325,275.52

TABLE II-B (Continued)

Data on Projects for Which Bids Were Taken During the Fiscal Year
July 1, 1968 - June 30, 1969

Name of Project	New or Addition	Number of Beds	County	Total Cost	Federal Share	State Share	Local Share
Diagnostic or Treatment Center							
North Carolina Baptist Hospital[3]	A		Forsyth	2,010,507.42	-0-	-0-	2,010,507.42
Community Mental Health Centers							
Harnett County Community Mental Health Center	N		Harnett	213,764.81	125,426.00	46,529.00	41,809.81
Lee County Community Mental Health Center	N		Lee	241,491.07	144,460.00	53,590.00	43,441.07
Mecklenburg County Mental Health Center	N		Mecklenburg	1,261,920.00	795,009.00	50,000.00	416,911.00
Sandhills Mental Health Center	A		Moore	565,017.42	342,069.84	50,000.00	172,947.58
Subtotal 4 Projects				2,282,193.30	1,406,964.84	200,119.00	675,109.46
Facilities for the Mentally Retarded							
Irene Wortham Day Care Center	N		Buncombe	239,629.25	132,264.60	49,065.90	58,298.75
Gaston Children's Center	A		Gaston	384,763.00	236,368.80	87,685.20	60,709.00
Mecklenburg Center for Human Development	N		Mecklenburg	401,814.35	220,370.92	-0-	181,443.43
East Carolina University Developmental Evaluation Clinic	N		Pitt	292,771.70	181,518.45	-0-	111,253.25
Subtotal 4 Projects				1,318,978.30	770,522.77	136,751.10	411,704.43
Total 25 Projects		1,090		60,185,943.84	16,345,660.71	1,190,674.84	42,649,608.29
Total 40 Construction Projects from July 1, 1967 - June 30, 1969				78,752,267.48	23,870,596.15	1,332,848.84	53,548,822.49

1 Special funds provided under Appalachian Regional Development Act
2 100% local expense
3 Funds are expected to be available from future allotment

A/C Air conditioning

TABLE III-A

State Appropriations to the Commission for the Construction of Medical Facilities

Year	Total Appropriation	Hospitals Health Centers Nurses' Residences	Long-Term Care Facilities	Community Mental Health Facilities	Mental Retardation
1947-1948	3,125,000	3,125,000			
1948-1949	3,125,000	3,125,000			
1949-1950	3,413,486	3,413,486			
1950-1951	3,413,486	3,413,486			
1951-1952	1,000,000	1,000,000			
1952-1953	1,000,000	1,000,000			
1953-1954	1,000,000	1,000,000			
1954-1955	1,000,000	1,000,000			
1955-1956	-0-	-0-			
1956-1957	-0-	-0-			
1957-1958	375,000	375,000			
1958-1959	375,000	375,000			
1959-1960	250,000	250,000			
1960-1961	250,000	250,000			
1961-1962	-0-	-0-			
1962-1963	-0-	-0-			
1963-1964	1,000,000	500,000	300,000	200,000	
1964-1965	1,000,000	500,000	300,000	200,000	
1965-1966	95,342				95,342
1966-1967	117,813				117,813
1967-1968	1,050,000	750,000		300,000	
1968-1969	1,050,000	750,000		300,000	
Totals	22,640,127	20,826,972	600,000	1,000,000	213,155

TABLE III-B

Federal Allotments to North Carolina for the Construction of Medical Facilities

Year	Total Federal Allotment	Hospitals, Health Centers, Nurses' Residences	Diagnostic and Treatment Centers	Chronic Disease Facilities	Nursing Homes	Rehibilitation Facilities	Accelerated Public Works	Planning Grants	Community Mental Health Centers	Facilities for the Mentally Retarded	Modernization	Appalachian Funds
1947-1948	3,429,016	3,429,016										
1948-1949	3,413,486	3,413,486										
1949-1950	6,414,042	6,414,042										
1950-1951	3,620,615	3,620,615										
1951-1952	3,715,001	3,715,001										
1952-1953	3,379,249	3,379,249										
1953-1954	2,877,889	2,877,889										
1954-1955	4,016,253	3,321,117	205,095	205,095	142,473	142,473						
1955-1956	4,656,299	3,949,179	208,707	208,707	144,853	144,853						
1956-1957	5,270,126	4,564,698	208,188	208,188	144,526	144,526						
1957-1958	5,033,778	4,334,784	206,177	206,177	143,320	143,320						
1958-1959	7,953,263	6,576,271	261,073	261,073	427,423	427,423						
1959-1960	7,787,383	6,436,503	256,774	256,774	418,666	418,666						
1960-1961	7,630,942	6,308,032	251,425	251,425	410,030	410,030						
1961-1962	8,693,299	6,284,490	563,082	817,223	752,087	276,417						
1962-1963	9,155,057	6,257,134	813,635	813,635	813,635	406,818	50,200					
1963-1964	10,120,902	5,934,767	771,374	771,374	771,374	385,687	1,486,326					
1964-1965	9,925,442	5,909,362	765,109	1,530,569*		382,030	-0-	16,215	1,050,372	271,785		
1965-1966	11,578,508	5,343,285	680,941	2,649,937*		369,608	-0-	44,805	1,498,962	352,524	638,446	
1966-1967	11,953,263	5,144,148	738,273	2,645,424*		368,236	-0-	12,059	1,491,856	430,665	972,602	150,000
1967-1968	12,143,158	4,675,381	693,565	2,496,917*		345,381	-0-	36,728	882,066	330,384	1,366,386	1,316,350
1968-1969	13,969,076	4,517,460	698,673	2,509,293*		299,435	-0-	-0-	881,659	329,988	1,515,922	3,216,646
Totals	156,736 047	106,405,909	7,322,091	20,000,198*		4,664,903	1,536,526	109,807	5,804,915	1,715,346	4,493,356	4,682,996

* Allotments for *Chronic Disease Facilities* and *Nursing Homes* are now combined in a single category *Long-Term Care Facilities*

Includes funds used to construct interchangeable beds in acute sections of general hospitals.

TABLE IV

Summary of Costs of Projects on Which Bids Were Received July 1, 1947 Through June 30, 1969

Fiscal Year	Number of Projects	Total Cost	Federal Share	State Share	Local Share	Average Percent Commission Participation
July 1, 1947 to June 30, 1948	5	1,514,527.34	496,675.79	379,555.92	638,295.63	57.9
July 1, 1948 to June 30, 1949	21	12,357,754.83	3,958,297.09	3,457,242.78	4,942,214.96	60.0
July 1, 1949 to June 30, 1950	21	16,571,746.63	4,584,486.79	2,729,172.76	9,258,087.08	44.1
July 1, 1950 to June 30, 1951	38	14,445,121.32	5,915,290.64	3,011,679.24	5,518,151.44	61.8
July 1, 1951 to June 30, 1952	17	11,899,900.24	4,679,549.51	1,416,064.20	5,804,286.53	51.2
July 1, 1952 to June 30, 1953	32	6,792,633.78	2,251,058.36	2,282,728.44	2,258,846.98	66.7
July 1, 1953 to June 30, 1954	30	5,220,479.41	2,239,630.15	1,041,435.71	1,939,413.55	62.8
July 1, 1954 to June 30, 1955	26	9,461,329.84	2,949,041.10	899,465.35	5,612,823.39	40.7
July 1, 1955 to June 30, 1956	29	9,001,113.99	4,331,531.01	888,619.62	3,780,963.36	58.0
July 1, 1956 to June 30, 1957	21	6,144,468.46	2,972,487.43	388,076.28	2,783,904.75	54.7
July 1, 1957 to June 30, 1958	29	16,448,981.23	7,810,529.53	1,146,230.87	7,492,220.83	54.5
July 1, 1958 to June 30, 1959	20	18,288,330.44	10,494,220.18	115,920.27	7,678,189.99	58.0
July 1, 1959 to June 30, 1960	19	8,385,717.26	4,458,550.44	207,270.09	3,719,896.73	55.6
July 1, 1960 to June 30, 1961	21	18,639,394.91	8,100,357.86	250,082.64	10,288,954.41	44.8
July 1, 1961 to June 30, 1962	11	12,009,054.22	6,392,759.61	8,401.00	5,607,893.61	53.3
July 1, 1962 to June 30, 1963	20	17,397,145.13	8,819,531.92	55,140.56	8,522,472.65	51.0
July 1, 1963 to June 30, 1964	19	27,095,585.79	11,248,436.56	536,676.64	15,310,472.59	43.5
July 1, 1964 to June 30, 1965	12	19,929,412.28	8,263,734.84	542,718.00	11,122,959.44	44.2
July 1, 1965 to June 30, 1966	9	9,317,553.67	4,234,667.00	192,780.00	4,890,106.67	47.5
July 1, 1966 to June 30, 1967	24	43,849,887.47	16,341,548.59	435,400.00	27,072,938.88	38.3
July 1, 1967 to June 30, 1968	15	18,812,235.31	8,524,935.44	142,174.00	10,145,125.87	46.1
July 1, 1968 to June 30, 1969	25	60,531,668.81	16,639,207.71*	1,190,674.84	42,701,786.26	29.5
Total	464	364,114,042.36	145,706,527.55	21,317,509.21	197,090,005.60	45.9
Average	21.1	16,550,638.29	6,623,023.98	968,977.69	8,958,636.62	
Approved projects for which bids will be taken after July 1, 1969	16	39,558,230.56	9,566,411.53*	1,018,965.00	28,972,854.03	
Total all projects approved July 1, 1947 to June 30, 1969	480	403,672,272.92	155,272,939.08	22,336,474.21	226,062,859.63	

* Federal share does not include $1,416,000.00 tentatively pledged to Lenoir Memorial Hospital, $1,000,000.00 to North Carolina Baptist Hospital, $529,221.07 to Grace Hospital, $1,900,000.00 to Gaston County Hospital, $500,000.00 to Northwestern District Hospital of Halifax County and $686,568.00 to Iredell Memorial Hospital from subsequent years' Federal allotments.

TABLE V

Summary Showing Construction Status of Medical Facilities ProjectsApproved Under Public Health Service Act (Title VI) and Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 as of June 30, 1969

Total All Projects	480	
Total Cost	$ 403,672,272.92	
Federal Share	$ 155,272,939.08	(38.5)
State Share	22,336,474.21	(5.5)
Local Share	226,062,859.63	(56.0)

	Total All Projects	General Hospitals Acute	General Hospitals LTC	Nursing Homes	T.B.	Mental	Rehab.	D & T	Health Centers	Nurses' Res.	Community Mental Health Centers	Mental Retardation
No. Projects	480[1]	233	31	5	2	7	17	22	93	49 (2,999)	12	9
No. Beds	16,930	14,355	977 (702)[2]	542	100	647	190				119	

	Number Projects	Cost Total	Cost Federal Share	Cost Local Share
State-Owned	21	$ 17,123,959.58	$ 5,687,594.09	$ 11,436,365.49
Projects Completed	414			
Projects Under Construction	50			
Projects in Planning Stage	16			
Total Number Current Projects	66			
Total Cost Current Projects	$ 151,587,305.75			

1 Where modernization funds have been combined with funds from another category, the modernization portion has not been counted as a separate project

2 Denotes beds constructed with Federal funds for long-term care facilities and planned architecturally to be used interchangeable for acute and chronic purposes as required by demand. Figures in parenthesis ( ) are included in the acute bed count.

TABLE VI

Projects Currently Under Construction
June 30, 1969

Project Number	County	Name of Project	No. of Beds	Total Cost	Federal Share	State Share	Local Share
General Hospitals							
NC-433A	Anson	Anson County Hospital	13	1,320,177.28	594,476.00	-0-	725,701.28
NC-450A&B	Ashe	Ashe County Memorial Hospital	76	2,619,468.97	1,543,182.00	100,000.00	976,286.97
NC-424A	Beaufort	Beaufort County Hospital	41	1,584,924.68	698,500.00	-0-	886,424.68
NC-462	Buncombe	Memorial Mission Hospital of Western North Carolina	25	2,496,828.00	265,828.00[2] 71,172.00	-0-	2,159,828.00
NC-449	Cherokee	District Memorial Hospital of Southwestern North Carolina	30	1,638,139.00	299,387.00[2] 817,668.50	100,000.00	421,083.50
NC-454A&B	Chowan	Chowan Hospital	60	1,886,935.39	600,000.00	108,000.00	1,178,935.39
NC-422A	Cumberland	Cape Fear Valley Hospital	131	4,805,992.59	1,500,000.00	-0-	3,305,992.59
NC-447A&B	Davidson	City Memorial Hospital	164	3,855,294.00	1,950,000.00	100,000.00	1,805,294.00
NC-436	Duplin	Duplin General Hospital	50	2,507,852.90	906,000.00	-0-	1,601,852.90
NC-435A	Edgecombe	Edgecombe General Hospital	16	955,000.00	525,250.00	-0-	429,750.00
NC-453C	Forsyth	North Carolina Baptist Hospital[1]	36	14,083,000.12	-0-	-0-	14,083,000.12
NC-444	Guilford	High Point Memorial Hospital	130	5,179,804.97	2,000,000.00	-0-	3,179,804.97
NC-446	Jackson	C. J. Harris Community Hospital	31	1,639,286.06	307,099.00[2] 895,618.35	100,000.00	336,568.71
NC-448A&B	Lenoir	Lenoir Memorial Hospital	285	9,259,625.50	1,584,000.00	100,000.00	7,575,625.50
NC-428	Lincoln	Lincoln County Hospital	100	2,149,903.55	990,000.00	-0-	1,159,903.55
NC-457	Montgomery	Montgomery Memorial Hospital	32	1,855,497.66	677,150.00	108,000.00	1,070,347.66
NC-432A&B	Nash	Nash County Hospital	292	8,313,502.00	3,000,000.00	-0-	5,313,502.00
NC-443A&B	Rutherford	Rutherford Hospital	70	4,587,893.70	400,000.00[2] 1,500,000.00	100,000.00	2,587,893.70
NC-434	Swain	Swain County Hospital	20	939,581.50	194,500.00[2] 427,900.00	-0-	317,181.50
NC-421A&C	Wayne	Wayne County Memorial Hospital	269	6,303,999.45	2,505,000.00	-0-	3,798,999.45
NC-437A	Wilkes	Wilkes General Hospital	30	1,049,039.12	157,000.00[2] 532,400.00	-0-	359,639.12
Subtotal 21 Projects			1,901	79,031,746.44	24,942,130.85	816,000.00	53,273,615.59

TABLE VI (Continued)

Projects Currently Under Construction
June 30, 1969

Project Number	County	Name of Project	No. of Beds	Total Cost	Federal Share	State Share	Local Share
Long-Term Care Facilities							
NC-433B	Anson	Anson County Hospital	30	834,576.42	405,524.00	-0-	429,052.42
NC-424B	Beaufort	Beaufort County Hospital	22	330,732.25	165,000.00	-0-	165,732.25
NC-422B	Cumberland	Cape Fear Valley Hospital	78	1,712,334.59	500,000.00	-0-	1,212,334.59
NC-435B	Edgecombe	Edgecombe General Hospital	36	600,000.00	330,000.00	-0-	270,000.00
NC-453A	Forsyth	North Carolina Baptist Hospital	176	2,753,728.46	1,000,000.00	-0-	1,753,728.46
NC-440	Henderson	Mountain Sanitarium and Hospital	50	884,300.00	150,000.00[2] 330,000.00	25,200.00	379,100.00
NC-429	Robeson	Southeastern General Hospital[1]	80	979,065.63	528,000.00	100,000.00	351,065.63
NC-421B	Wayne	Wayne County Memorial Hospital	75	1,696,000.55	495,000.00	-0-	1,201,000.55
NC-437B	Wilkes	Wilkes General Hospital	30	600,000.00	330,000.00	-0-	270,000.00
Subtotal	9 Projects		577	10,390,737.90	4,233,524.00	125,200.00	6,032,013.90
Public Health Centers							
NC-461	Buncombe	Buncombe Co. Health Center		2,505,136.32	300,000.00	-0-	2,205,136.32
NC-445	Caswell	Caswell Co. Health Center		133,585.66	49,024.25	37,804.74	46,756.67
NC-438	Onslow	Onslow Co. Health Center		145,982.53	72,600.00	-0-	73,382.53
Subtotal	3 Projects			2,784,705.51	421,624.25	37,804.74	2,325,275.52
Diagnostic or Treatment Centers							
NC-453B	Forsyth	North Carolina Baptist Hospital[3]		2,010,507.42	-0-	-0-	2,010,507.42
NC-403	Orange	North Carolina Memorial Hospital		10,240,679.00	2,487,375.00	-0-	7,753,304.00
Subtotal	2 Projects			2,251,186.42	2,487,375.00	-0-	9,763,811.42

1 The general hospital portion of this project is to be funded at 100% local expense
2 Special funds provided under Appalachian Regional Development Act
3 This portion of total project is to be funded from subsequent years' Federal allotments.

Rehabilitation Facilities							
NC-442	Durham	Duke University Medical Center		1,036,176.00	612,059.00	-0-	424,117.00
NC-451	Mecklenburg	Charlotte Rehabilitation Hosp.		279,783.45	128,991.00	-0-	150,792.45
Subtotal 2 Projects				1,315,959.45	741,050.00	-0-	574,909.45
Community Mental Health Centers							
NC-MH-2	Cumberland	Cape Fear Valley Hospital Mental Health Center	31	1,005,899.16	633,483.54	50,000.00	322,415.62
NC-MH-11	Harnett	Harnett County Mental Health Ctr.		213,764.81	125,426.00	46,529.00	41,809.81
NC-MH-1	Jackson	Western Carolina University Mental Health Center		256,609.34	50,000.00[2] 134,246.70	-0-	72,362.64
NC-MH-10	Lee	Lee County Mental Health Center		241,491.07	144,460.00	53,590.00	43,441.07
NC-MH-6	Mecklenburg	Mecklenburg County Mental Health Center		1,261,920.00	795,009.00	50,000.00	416,911.00
NC-MH-7	Moore	Moore Memorial Hospital Mental Health Center	20	565,017.42	342,069.84	50,000.00	172,947.58
NC-MH-5	Robeson	Southeastern General Hospital Mental Health Center	25	563,847.71	346,500.00	50,000.00	167,347.71
Subtotal 7 Projects			76	4,108,549.51	2,571,195.08	300,119.00	1,237,235.43
Mental Retardation Facilities							
NC-MR-5	Buncombe	Irene Wortham Day Care Center		239,629.25	132,264.60	49,065.90	58,298.75
NC-MR-6	Gaston	Gaston Children's Center for Mentally Retarded		384,763.00	236,368.80	87,685.20	60,709.00
NC-MR-2	Granville	Board of Juvenile Correction Mental Retardation Facility		504,054.00	317,554.00	-0-	186,500.00
NC-MR-1	Jackson	Western Carolina University Mental Retardation Facility		323,158.66	50,000.00[2] 168,007.14	-0-	105,151.52
NC-MR-7	Mecklenburg	Mecklenburg Center for Human Development		401,814.35	220,370.92	-0-	181,443.43
NC-MR-4	Pitt	East Carolina University Developmental Evaluation Clinic and Day Care Center		292,771.70	181,518.45	-0-	111,253.25
Subtotal 6 Projects				2,146,190.96	1,306,083.91	136,751.10	703,355.95
Total 50 Projects Under Construction			2,554	112,029,075.19	36,702,983.09	1,415,874.84	73,910,217.26

TABLE VII

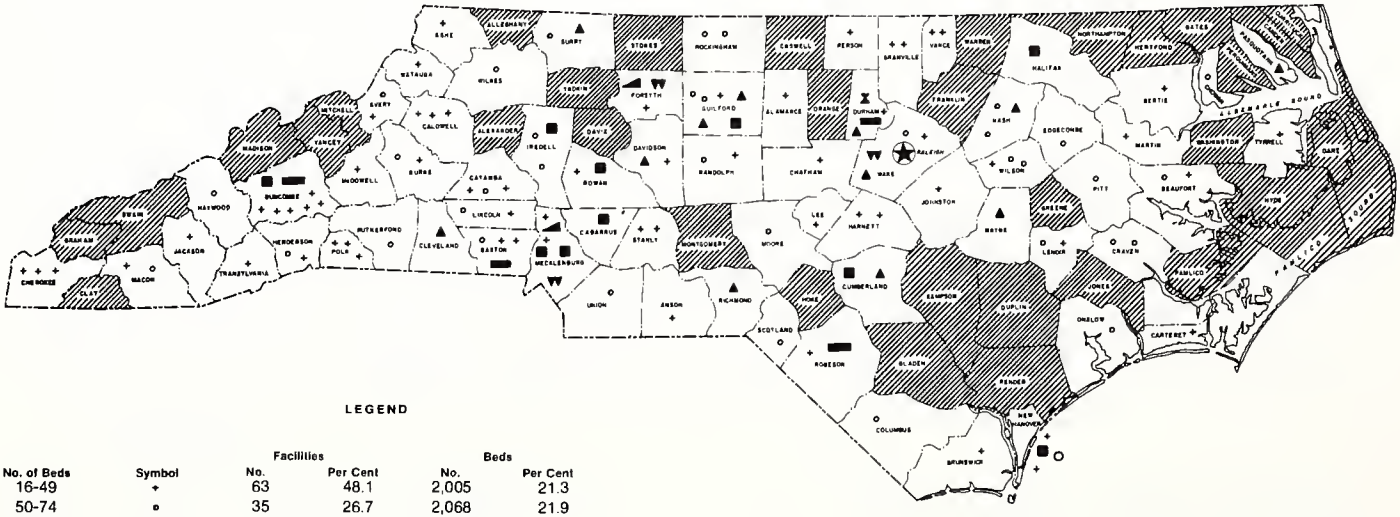
Projects Currently in Planning Stage
For Which Bids Will Be Taken After
July 1, 1969

Project Number	County	Name of Project	No. of Beds	Total Cost	Federal Share	State Share	Local Share
General Hospitals							
NC-420A&B	Burke	Grace Hospital	161	5,294,874.00	2,216,000.00[1] 1,054,778.93	-0-	2,024,095.07
NC-452A&B	Gaston	Gaston County Hospital	500	15,000,000.00	100,000.00	108,000.00	14,792,000.00
NC-455A&B	Halifax	Northwestern District Hospital of Halifax County	150	4,500,000.00	1,000,000.00	108,000.00	3,392,000.00
NC-459	Iredell	Iredell Memorial Hospital	82	3,216,421.00	600,000.00	108,000.00	2,508,421.00
NC-456	Martin	Martin County Hospital	50	2,072,730.00	500,000.00	108,000.00	1,464,730.00
NC-458A&B	Polk	St. Luke's Hospital	75	2,997,000.00	660,000.00	19,800.00	2,317,200.00
NC-463A	Wilson	Wilson Memorial Hospital	38	677,966.00	271,186.00	58,000.00	348,780.00
Subtotal	7 Projects		1,056	33,758,991.00	6,401,964.93	509,800.00	26,847,226.07
Long-Term Care Facilities							
NC-460	Stanly	North Carolina Lutheran Nursing Home	51	734,329.56	273,200.00	52,591.00	408,538.56
NC-463B	Wilson	Wilson Memorial Hospital	40	596,600.00	238,640.00	50,000.00	307,960.00
Subtotal	2 Projects		91	1,330,929.56	511,840.00	102,591.00	716,498.56
Rehabilitation Facilities							
NC-464	Buncombe	Asheville Orthopedic Hospital	24	830,030.00	135,000.00[1] 514,618.60	-0-	180,411.40

Community Mental Health Centers							
NC-MH-8	Buncombe	Blue Ridge Mental Health Ctr.		333,333.00	206,666.00	76,667.00	50,000.00
NC-MH-12	Edgecombe	Edgecombe-Nash Mental Health Ctr.		400,000.00	248,000.00	92,000.00	60,000.00
NC-MH-9	Johnston	Johnston Memorial Hospital Mental Health Center	20	770,000.00	477,400.00	100,000.00	192,600.00
NC-MH-4	Wilson	Wilson Co. Mental Health Ctr.	23	1,020,000.00	632,400.00	100,000.00	287,600.00
Subtotal	4 Projects		43	2,523,333.00	1,564,466.00	368,667.00	590,200.00
Mental Retardation Facilities							
NC-MR-8	Durham	Duke-Civitan Center Developmental Evaluation Clinic		572,467.00	102,184.00	37,907.00	432,376.00
NC-MR-9	Guilford	Guilford County Mental Retardation Complex		542,480.00	336,338.00	-0-	206,142.00
Subtotal	2 Projects			1,114,947.00	438,522.00	37,907.00	638,518.00
Total	16 Projects		1,214	39,558,230.56	9,566,411.53	1,018,965.00	28,972,854.03

[1] Special funds provided under Appalachian Regional Development Act

SIZE AND LOCATION OF GENERAL AND ALLIED HOSPITALS
(EXCLUDING MENTAL AND TUBERCULOSIS)
December 1, 1947



LEGEND

No. of Beds	Symbol	Facilities No.	Facilities Per Cent	Beds No.	Beds Per Cent
16-49	+	63	48.1	2,005	21.3
50-74	o	35	26.7	2,068	21.9
75-99	▲	12	9.2	1,029	10.9
100-149	■	10	7.6	1,138	12.1
150-199	▬	4	3.0	665	7.1
200-299	W	3	2.3	776	8.2
300-399	O	1	.8	304	3.2
400-499	◢	2	1.5	883	9.4
500-Over	⧗	1	.8	558	5.9
TOTAL		131	100.0	9,426	100.0

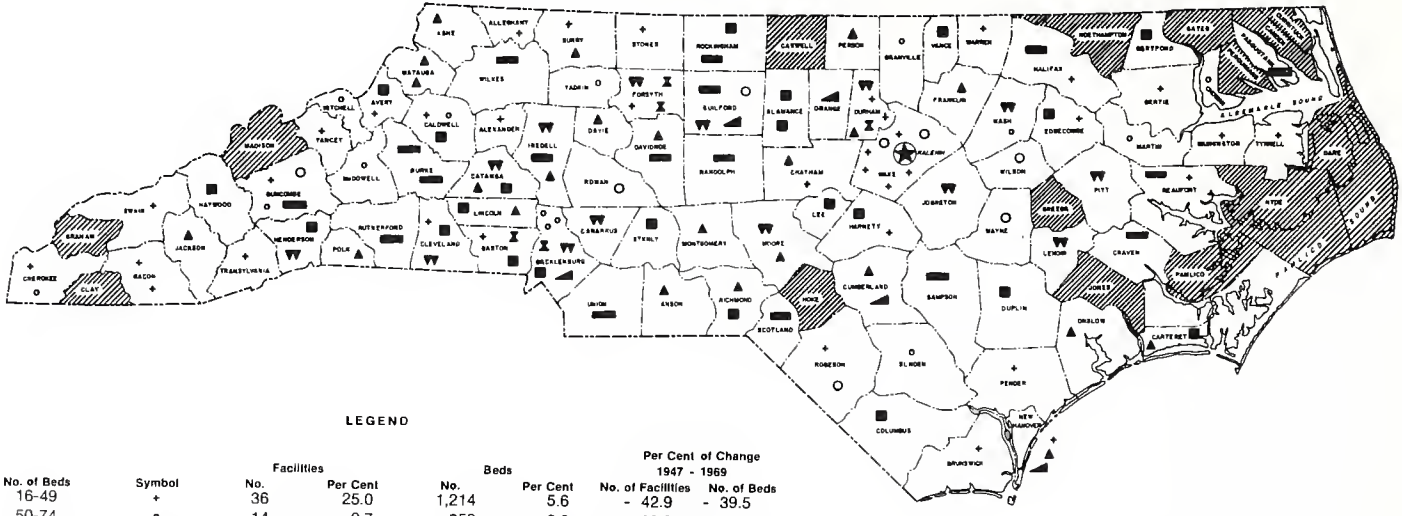
NOTE: Does not include facilities of 15 beds or less.

Counties with no general hospital

SIZE AND LOCATION OF GENERAL AND ALLIED HOSPITALS INCLUDING PROJECTS UNDER CONSTRUCTION AND IN PLANNING

(EXCLUDING MENTAL AND TUBERCULOSIS)

June 30, 1969



LEGEND

No. of Beds	Symbol	Facilities No.	Facilities Per Cent	Beds No.	Beds Per Cent	Per Cent of Change 1947 - 1969 No. of Facilities	No. of Beds
16-49	+	36	25.0	1,214	5.6	- 42.9	- 39.5
50-74	o	14	9.7	852	3.9	- 60.0	- 58.8
75-99	▲	23	16.0	1,977	9.2	+ 91.7	+ 92.1
100-149	■	22	15.3	2,667	12.4	+120.0	+134.4
150-199	▬	17	11.8	2,868	13.3	+325.0	+331.3
200-299	▼	14	9.7	3,346	15.6	+366.7	+331.2
300-399	O	8	5.5	2,888	13.4	+700.0	+850.0
400-499	◢	5	3.5	2,238	10.4	+150.0	+153.5
500-Over	⧗	5	3.5	3,488	16.2	+400.0	+525.1
TOTAL		144	100.0	21,538	100.0	+ 9.9	+128.5

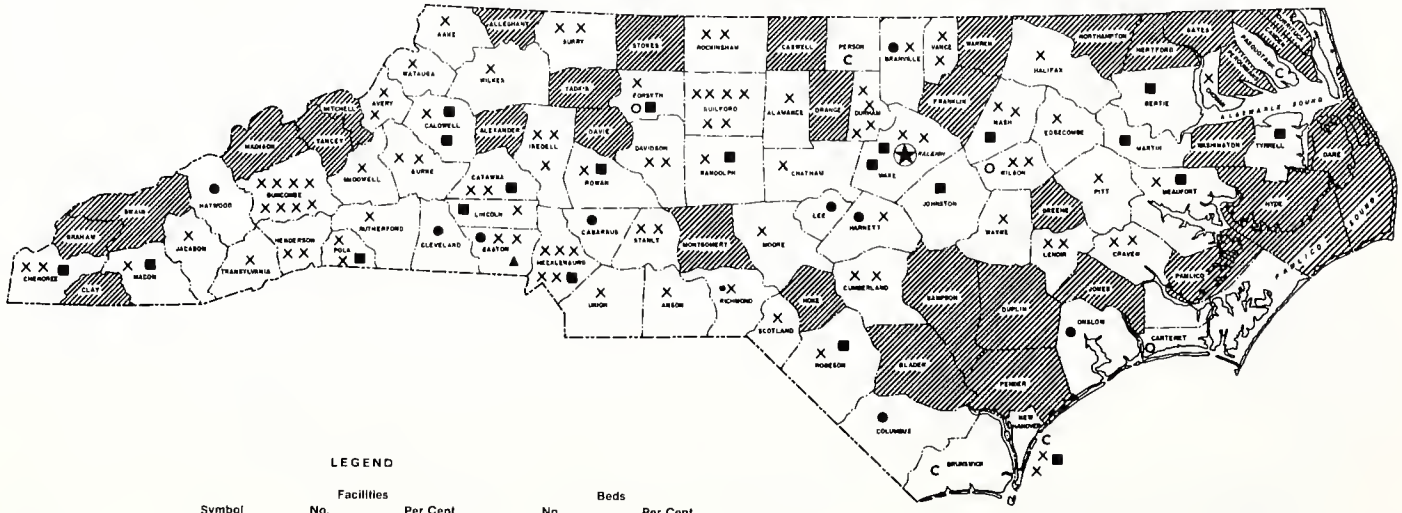
NOTE: Does not include facilities of 15 beds or less.

▨ Counties with no general hospital

OWNERSHIP OF GENERAL AND ALLIED HOSPITALS

(EXCLUDING MENTAL AND TUBERCULOSIS)

December 1, 1947



LEGEND

	Symbol	Facilities No.	Facilities Per Cent	Beds No.	Beds Per Cent
City	O	3	2.3	523	5.6
City-County	C	4	3.0	284	3.0
State	▲	1	.8	160	1.7
County	●	9	6.9	503	5.3
Nonprofit Assoc.	×	93	71.0	7,323	77.7
Proprietary	■	21	16.0	633	6.7
Authority	▲▲				
TOTAL		131	100.0	9,426	100.0

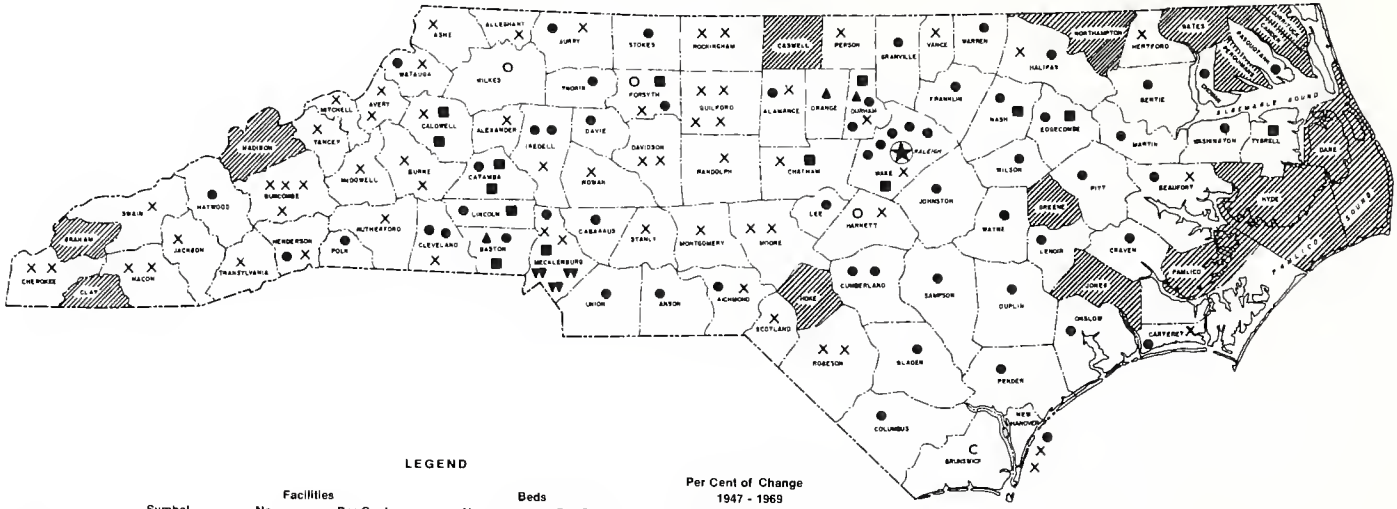
NOTE: Does not include facilities of 15 beds or less

Counties with no general hospitals.

OWNERSHIP OF GENERAL AND ALLIED HOSPITALS INCLUDING PROJECTS UNDER CONSTRUCTION AND IN PLANNING

(EXCLUDING MENTAL AND TUBERCULOSIS)

June 30, 1969



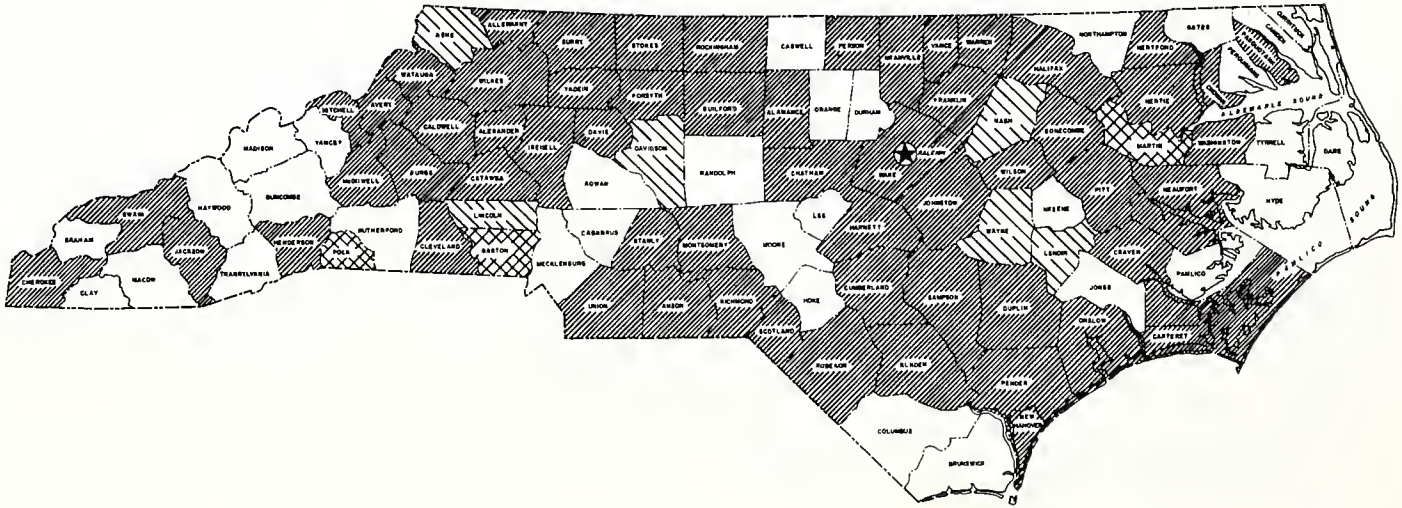
LEGEND

	Symbol	Facilities No.	Facilities Per Cent	Beds No.	Beds Per Cent	Per Cent of Change 1947 - 1969 No. of Facilities	Per Cent of Change 1947 - 1969 No. of Beds
City	O	3	2.1	547	2.5	0.0	+ 4.6
City-County	C	1	.7	42	.2	- 75.0	- 85.2
State	▲	3	2.1	622	2.9	+200.0	+ 288.7
County	●	58	40.3	9,295	43.2	+544.4	+1,747.9
Nonprofit Assoc.	×	62	43.0	9,309	43.2	- 33.3	+ 27.1
Proprietary	■	14	9.7	699	3.2	- 33.3	+ 10.4
Authority	▲▲	3	2.1	1,024	4.8	—	—
TOTAL		144	100.0	21,538	100.0	+ 9.9	+ 128.5

NOTE: Does not include facilities of 15 beds or less.

Counties with no general hospitals.

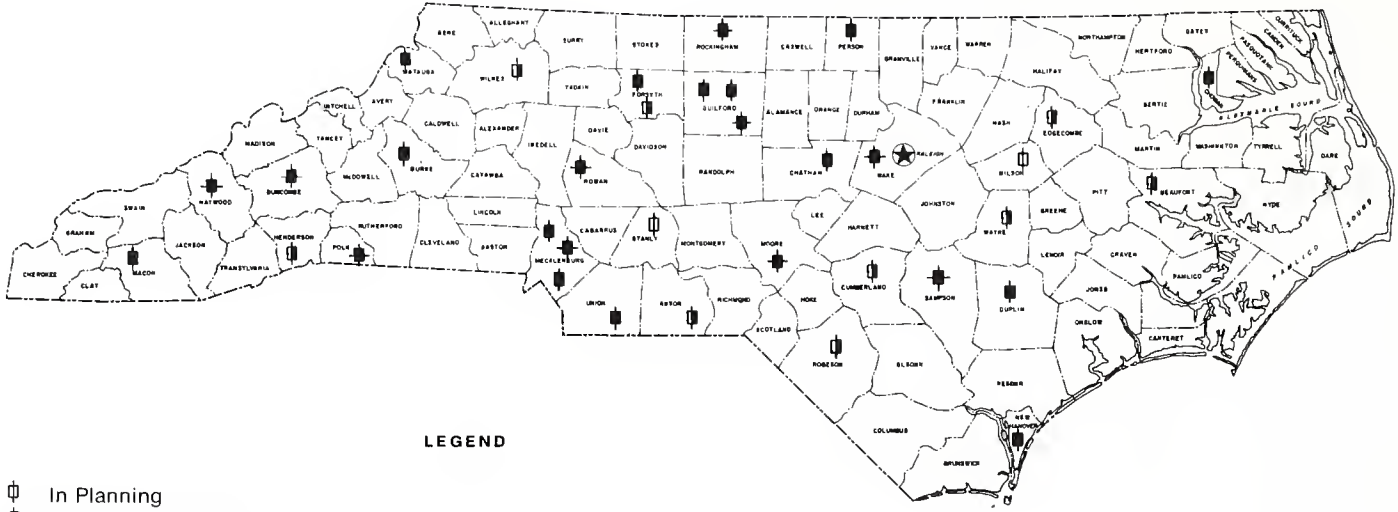
68 COUNTIES WITH ALL-NEW GENERAL HOSPITALS AIDED BY THE COMMISSION 1947 - 1969



LEGEND

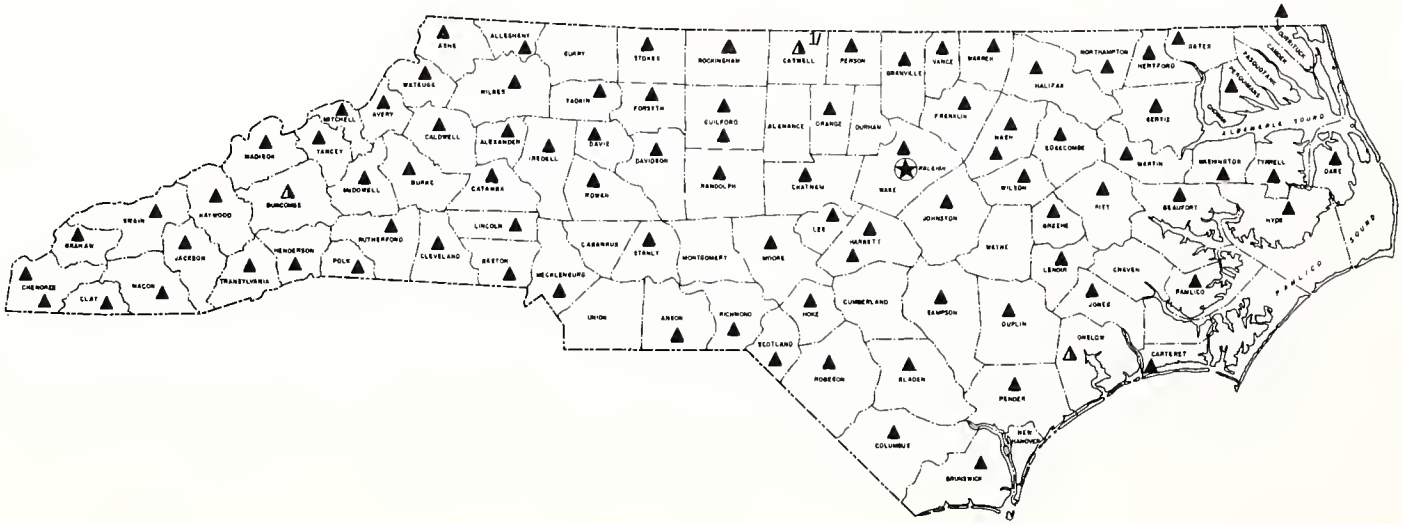
- Facilities In Planning
- Facilities Under Construction
- Completed Facilities

LONG - TERM CARE FACILITIES
CONSTRUCTION PROGRAM
1954 - 1969[1]


LEGEND
In Planning
Under Construction
Completed Facilities
Constructed With LTC Funds — Beds Currently Being Used As Acute General Beds

[1] Special Funds For Construction Of LTC Facilities First Became Available July 1, 1954.

PUBLIC HEALTH CENTERS
CONSTRUCTION PROGRAM
1947 - 1969

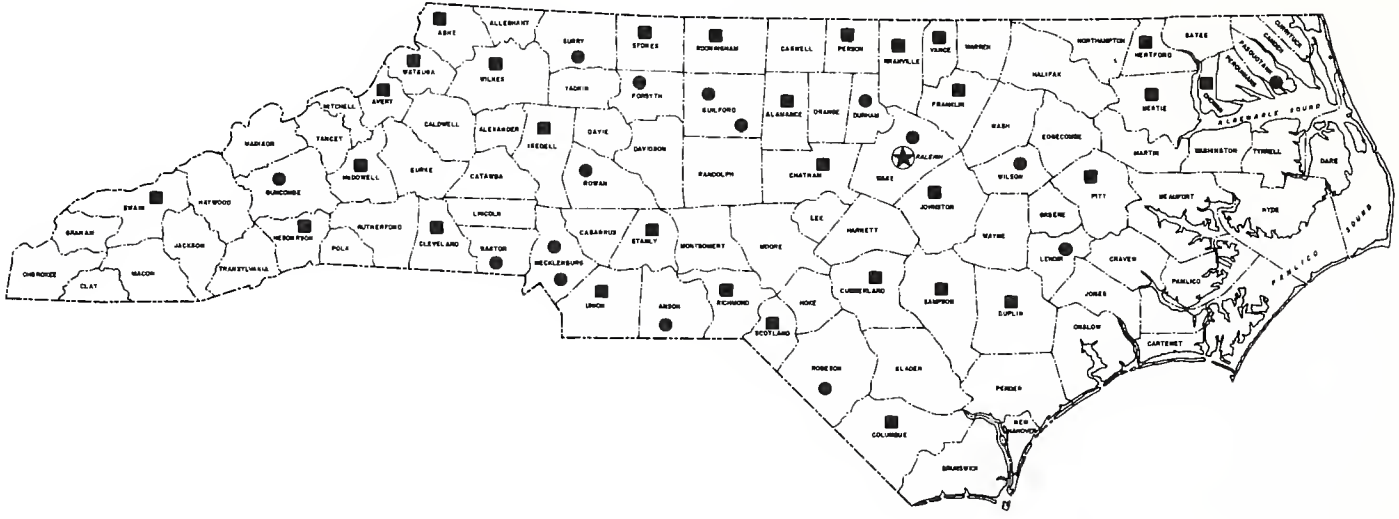


LEGEND

- ▲ Under Construction
- ▲ Completed Facilities

[1] Relpaces Existing Facility

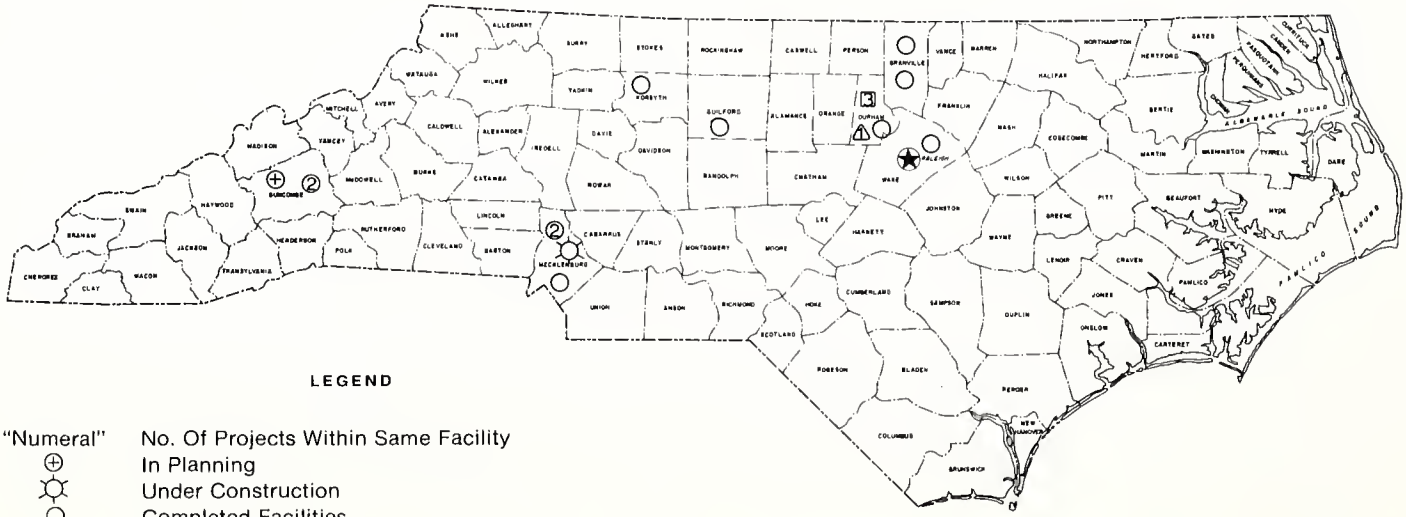
NURSES' RESIDENCES — SCHOOLS OF NURSING
CONSTRUCTION PROGRAMS
1947 - 1969



LEGEND

- ■ Completed Nurses' Residences
- ● Completed Schools of Nursing

REHABILITATION FACILITIES CONSTRUCTION PROGRAM 1954 - 1969[1]



LEGEND

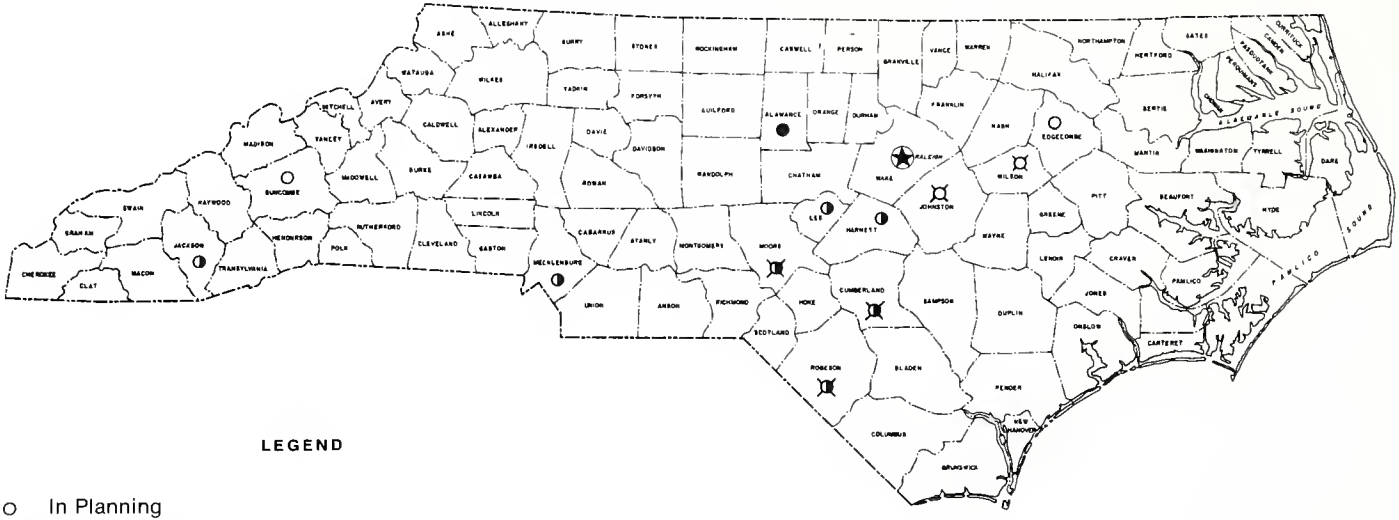
"Numeral"	No. Of Projects Within Same Facility
⊕	In Planning
☼	Under Construction
○	Completed Facilities

DUKE UNIVERSITY MEDICAL CENTER (Durham County)

- ⚠ Under Construction
- 3 Completed Facilities

[1] Special Funds For Construction Of Rehabilitation Facilities First Became Available July 1, 1954.

COMMUNITY MENTAL HEALTH CENTER CONSTRUCTION PROGRAM 1964 - 1969[1]



LEGEND

- ○ In Planning
- ● Under Construction
- ⊠ Project Including Psychiatric Beds (In Planning)
- ⊠ Project Including Psychiatric Beds (Under Construction)
- ◑ Completed Facility

[1] Special Funds For Construction Of Community Mental Health Center First Became Available July 1, 1964.

FACILITIES FOR THE MENTALLY RETARDED
CONSTRUCTION PROGRAM
1964 - 1969[1]

LEGEND

- ○ In Planning
- ◑ Under Construction
- ● Completed Facility

[1] Special Funds For Construction Of Facilities For The Mentally Retarded First Became Avalable July 1, 1964.

PART II

SPECIAL STUDIES

Small Hospital Maintenance Demonstration Project

A study authorized in the previous biennium was completed and published at the end of the 1967-1969 period under the title *A Study of Plant and Equipment Maintenance Problems in Small Hospitals - A Recommended Plan to Improve Engineering Services*. The study, financed by a U. S. Public Health Service grant, revealed gross deficiencies in plant maintenance, especially in hospitals of limited size located in the smaller communities. The purpose of this study was to demonstrate by contracting with graduate engineers the value of their services in consulting with the smaller hospitals. The conclusions and recommendations of the study are summarized below:

Conclusions

1. The plant and equipment of the smaller hospitals, especially those of under 100 beds and in communities of limited resources, as a rule, are inadequately maintained because of the hospitals':

   a. Inability to attract trained personnel
   b. Limited financial resources
   c. Lack of interest in this aspect of management

   Generally, the maintenance of these facilities is systemless. The majority are preoccupied with "brush-fire" operations.

2. Engineering staffs lack the educational and technical background to understand the sophistication of modern-day hospital equipment and are not encouraged or provided the opportunity to acquire the expertise necessary to assure its effective use.

3. Large investments are being made unnecessarily in equipment that will not be used for its intended purpose and/or being spent to replace equipment that has deteriorated as a result of poor maintenance. Accordingly, equipment for hospitals should be selected on the basis of the availability of adequate maintenance before its other aspects are considered.

4. The general lack of understanding of the function and proper maintenance of certain sensitive equipment can transform life-saving equipment into life-taking gadgetry.

5. The growing complexity and sophistication of equipment and mechanical systems is compounding the problem of obtaining

intelligent maintenance and this problem will be multiplied at a faster pace as new systems are designed.

6. Management places too low a priority in budgeting resources for the maintenance department.

7 Professional engineering consultation on a contractual basis to supplement efforts of the full-time maintenance staff is an effective and economical means of assuring efficient functioning of hospital mechanical systems and equipment.

Time and again the consultants' reports revealed that small hospitals are unadvised of the sizable costs resulting from inadequate maintenance of mechanical and electrical equipment and that emergencies developing from improper care can be reduced by at least two-thirds in less than two years with the employment of competent professional engineering consultation. Recurring examples were discovered during this study of the acceptance by hospitals of improperly installed equipment due greatly to the laxity in inspections by architects, design engineers, and regulatory agencies.

The study definitely points up the urgent need for developing training opportunities for hospital maintenance personnel and for continuing education programs to allow employees responsible for plant maintenance to keep abreast of new developments in hospital mechanical systems and equipment.

Recommendations

Hospitals of limited size which cannot justify full-time trained professional engineers should individually or in concert with neighboring facilities retain professional engineering consultation on a *regular*, if only part-time, basis as a means of lowering depreciation and increasing the efficiency of equipment and of protecting patients and personnel from the hazards of improper installations. Hospital management needs to be impressed with the urgency of improved engineering services.

The extent of the problem is such that public and private agencies should consider the feasibility of obtaining assurance in exchange for their grants for hospital plant capitalization that equipment will be properly maintained through an adequate and approvable maintenance program.

Finally, the hospitals and their State Associations and the Hill-Burton and licensing agencies should press for apprentice training programs for maintenance employees either in in-plant arrangements with the larger facilities, a formal curriculum at technical institutes or a combination of both.

Because of the increasing sophistication in the mechanical systems specified for hospital projects developed with Hill-Burton aid and the expense involved in depreciation resulting from the lack of understanding of their function, care and repair, the Medical Care Commission adopted the policy, as a result of this study, requiring as a condition of its assistance to construction projects that the applicant provide assurance that the buildings, mechanical systems and equipment will be adequately maintained following the completion of the project.

Planning Guide for Coronary Care Units

North Carolina hospitals over the past several years have shown increased interest in providing a clinical environment separate from all others to furnish specialized care for patients with acute heart disease. In an attempt to be of service to hospitals, the Medical Care Commission brought together knowledgeable individuals from many organizations and professions for the purpose of studying the current status of the various aspects of planning and operating coronary care units. It was unusual to discover that very little information has been published on the subject. As a consequence, the staff, with the advice of this ad hoc committee, developed a suggested guide for planning coronary care units for North Carolina hospitals.

The guide outlines steps for setting up coronary care units, defines general elements of operation including staffing patterns. It includes a section on the general elements of design and for the first time made available for general distribution a recommended system of electrical circuitry to be employed in coronary care units.

This publication, entitled *Coronary Care Units — A Suggested Planning Guide for North Carolina Hospitals*, has been furnished all North Carolina hospitals licensed by the Medical Care Commission and it has received national distribution as well. It is understood that a number of states have adopted this guide as recommended standards for their hospitals.

Hospital Emergency Services

Stimulated by the growing concern over the increasing problem of emergency services and hospitals' inability to meet accelerated public demands, the Medical Society of the State of North Carolina asked the Medical Care Commission to strengthen its efforts in licensing hospitals with regards to emergency room services and particularly with reference to the availability of physicians to emergency rooms and the establishment of minimum standards for personnel and equipment. Because of the growing criticism on the part of the public about difficulties in obtaining around-the-clock treatment in many hospital emergency rooms, the Commission was greatly interested in studying this problem. An ad hoc committee representing the medical, hospital and nursing professions was convened to recommend steps for bringing about attainable solutions.

It is apparent that the hospital emergency room, which in its inception symbolized the epitome of efficient and compassionate care of the sick and injured, now faces the contention by many that the hospital emergency department is representative of everything that is wrong with America's health care delivery system. In hospital emergency services, we see dramatically revealed the inadequacies resulting from the critical shortages and maldistribution of physical manpower, the shortage of trained paramedical personnel, inefficient utilization of existing health personnel, substandard and poorly equipped facilities and a tragic lack of coordination of existing health resources. These conditions, compounded by the startling increase in demands upon hospital emergency departments, reveal not only that there are more actual emergencies, but also that the public is increasingly looking to hospital emergency departments to provide general health care which cannot, without difficulty, be obtained elsewhere. Physicians and hospitals are making a commendable but, for the most part, futile effort to provide ambulatory care commensurate with the public's expectations.

The committee found that over half of the visits to hospital emergency services could not be classified as true emergencies. Notwithstanding this fact, in 1969 North Carolina hospitals experienced 1,122,000 visits to the emergency rooms, almost one and one-half times the number of inpatients discharged during the same period. The problem is more acute, of course, in the smaller, rural hospitals where medical staffs are critically limited.

The committee concluded that the problem almost defies solution in view of the disparity between demands for service and the resources available to provide it at most of the hospitals in the State. To expect comprehensive emergency coverage at the limited-service hospitals is greatly unrealistic and yet, the general public feels that his needs can be or should be accommodated at any hospital emergency room at any time of the day or night. Not every hospital can afford or support 24-hour emergency coverage. Accordingly, *the committee recommended that hospital emergency departments be classified and defined according to the types of care permitted by their physical and professional resources. In order to more nearly expedite uniform and adequate care throughout the State, it proposed five types of emergency services: comprehensive emergency centers, general emergency centers, intermediate emergency departments, limited service emergency units and first aid emergency units.* These vary from the highly sophisticated comprehensive service available at medical school hospitals to the small, rural hospital with limited resources in personnel and equipment.

The full text of the report to the Medical Care Commission was in preparation toward the end of the biennium. The Medical Care Commission plans to have the conclusions of the study reviewed by the various professional organizations — the Medical Society of the State of North Carolina, the State Hospital Association, etc. — and to have the reactions of these groups evaluated before proposing any regulations that would affect licensed hospitals. Other aspects of the problem of emergency room service will, in time, be studied by this or other committees; namely, transportation and communication, financing and staffing.

Study to Establish Planning Guides for Hospital X-Ray Departments

At the request of the North Carolina Radiological Society, the Commission's staff agreed to develop with its assistance planning guides for hospital X-ray departments, hopefully along the lines of the guide developed for coronary care units. At the end of the biennium, it was not certain how comprehensive this study needs to be in the wake of planning guides for radiologic installations that have come to light during the course of the committee's investigation.

PART III

THE HOSPITAL LICENSING PROGRAM

In April, 1966, the State Board of Health contracted with the Medical Care Commission to conduct surveys of hospitals not accredited by the Joint Commission on Accreditation of Hospitals for the purpose of determining their eligibility for certification as participants in the Federal Health Insurance for the Aged (Medicare) Program. During the period July 1, 1967-June 30, 1969, the licensing staff of the Commission, in order to comply with Federal deadlines, devoted a major portion of its time surveying and providing consultation to hospitals as a means of assisting them in complying with Social Security standards.

To meet its responsibilities under the Medicare contract, the Commission added to its staff a medical records consultant and a nurse consultant to assist primarily in Medicare surveys and to provide consultation to participating hospitals. A team approach was developed using hospital, nurse and medical records consultants.

Because of the preponderance of deficiencies noted during the early surveys, considerable numbers of visits to each facility were required during the initial period. Problems were noted primarily in the areas of nursing service, medical records and in medical staff organization and functions. It was found that in the area of nursing service the primary deficiency was reflected in the lack of an adequate number of registered nurses and in their availability on a 24-hour basis. During the period 1967 to 1969, a number of hospitals previously found to be deficient in this area were able to acquire the additional nurses necessary to comply with this condition of the Social Security standards. With the assistance and advice of the Commission's medical records consultant, there has been a noticeable upgrading in medical record departments and in medical staff organization to fit the Federal criteria.

As of March, 1969, of the 165 licensed facilities, 146 were certified to participate in Medicare. In addition, 10 extended care facilities owned and operated by hospitals were certified to participate in the program. From a total of 22,000 licensed beds, approximately 21,400 were certified at the end of the last biennium, representing about 98% of all licensed beds in the State.

Surveys of licensed Joint Commission-accredited hospitals were curtailed during the period because of the extra Medicare workload and the difficulty in attracting qualified surveyors. Fortunately, problems among the accredited hospitals were noticeably fewer and these hospitals, accordingly, have required less surveillance. With increased demands for higher standards, however, closer evaluation of all hospitals can be anticipated.

Other activities of the licensing section involved working with hospitals to help them comply with the State's requirements for providing more adequate pharmaceutical services and for them to be registered with the

State Board of Pharmacy. Of the 165 hospitals licensed by the Medical Care Commission, 150 were required to obtain the services of a full- or part-time pharmacist in order to comply with State laws relating to the compounding and dispensing of drugs. When the Commission, with the cooperation of the State Board of Pharmacy and the School of Pharmacy at Chapel Hill, commenced the program in 1963 to upgrade hospital pharmacies, there were only 37 hospitals in the State whose pharmacies were registered with the State Board. By June 30, 1967, there were 80 hospitals with registered pharmacies. By June, 1969, the pharmacies of 127 were registered. This represents 85% of the hospitals licensed by the Medical Care Commission.

The licensing section's staff aided other sections of the Commission in developing a coronary care guide which has been published and distributed to all North Carolina hospitals as a means of assisting them in establishing units which will conform to recognized operational and engineering standards. As has been mentioned elsewhere in this report, the staff also aided in the Commission's study of hospital emergency services, the purpose of which was to define problems related to emergency coverage in North Carolina to attempt to establish standards for improving emergency care at licensed hospitals. At the end of the biennium, the study was still underway and a report within the next year is expected to be published on the findings and recommendations resulting from this important study.

The following tables summarize statistically the status and utilization of hospitals for the indicated periods:

Licensed Hospitals by Bed Capacity

Size by Beds	Number			Beds			Average	No. of	Beds
	1966	1968	1969	1966	1968	1969	1966	1968	1969
3- 15	13	11	6	112	92	70	9	8.4	12
16- 30	16	14	13	369	304	288	23	21.7	22
31- 50	33	35	30	1,391	1,462	1,241	42	41.8	41
51- 75	20	15	16	1,254	970	997	63	64.7	62
76-100	23	24	25	2,082	2,166	2,263	91	90.3	91
101-150	22	22	23	2,765	2,759	2,861	126	125.4	124
151-200	16	16	16	2,874	2,871	2,814	180	179.4	176
201-300	12	11	12	2,864	2,656	2,948	239	241.5	246
301-400	4	5	7	1,535	1,816	2,551	384	363.2	364
400- up	9	12	11	5,360	6,835	6,464	596	569.6	588
	168	165	159	20,606	21,931	22,497	123	132.9	141

Licensed Hospitals by Medical Type

	1966	1968	1969
General	144	143	143
Mental	0	0	0
Tuberculosis	4	4	4
Rehabilitation	4	4	4
Maternity	0	0	0
Pediatric	1	1	1
Eye, Ear, Nose, Throat	2	2	2
Physician Clinic	12	10	4
Chronic Disease	1	1	1
	168	165	159

	1966	1968	1969
A. Percentage of occupancy (excluding newborn)	74.4	71.8	72.7
B. Average length of stay (excluding newborn)	7.5	7.7	7.7
C. Total patients discharged	722,420	725,419	747,526
Newborn discharged	81,180	81,562	84,336
Total discharged less newborn	641,240	643,857	663,190
D. Total patient days	5,150,361	5,359,049	5,535,712
Newborn days	358,351	369,377	378,521
Total days less newborn days	4,792,010	4,989,672	5,157,191
E. Total outpatient visits	1,306,795	1,457,495	1,589,414
F. Employees per patient per day	Not Available	2.53	2.4
G. Total surgical procedures	304,829	323,815	299,806
H. Number medical patients discharged	218,254	218,962	230,559
I. Number pediatric patients discharged (excluding newborn)	60,836	72,178	71,435
J. Number maternity and gynecological patients discharged	139,454	142,798	146,801
K. Number other patients discharged	222,696	209,919	214,395
L. Number deaths (excluding stillbirths)	20,182	20,991	21,854
M. Number autopsies	4,476	4,635	4,592

PART IV

EDUCATIONAL LOANS FOR MEDICAL AND RELATED STUDIES

In view of the increasing concern in North Carolina over the physician shortages in rural communities, the experience of the program as it relates to *medical student loan recipients* is described more in detail in the following passages:

The first medical student received a loan from the Commission in 1946. Even in the early days of the program when recipients did not plan residencies, it was 1953, or seven years after receiving his initial loan, before the first physician was available and commenced his rural practice under the terms of the loan agreement. The original law of 1945 intended that loan recipients agree to practice in communities of less than 2,500 population. The law was subsequently modified to permit the Medical Care Commission itself to define the type of community and now the population ceiling is established by regulation at 10,000.

The following summarizes the experience of the program up to April, 1969:

Two hundred twenty-six (226) medical students received loans with 155 attending the three North Carolina medical schools and 71 enrolled in 11 out-of-state institutions.

Attrition rate by academic failure and withdrawal from school has been lower among those attending schools outside of North Carolina.

Non-white students represent 24% of the total number approved, or 54. (The 1960 census indicated that non-whites comprised 25.4% of the State's total population.) The academic failure rate for non-white has been the same as for white recipients, although the latter withdrew from their training programs at a higher rate — non-white 1.8%; whites, 4.9%.

As of April, 1969, 52%, or 23, of the recipients *in school* were white and 48%, or 21, were non-white. Women students numbered 8 and represented slightly over 18% of those currently enrolled in the four years of professional training.

An additional 39 recipients were in a deferred status completing internships, residencies and/or military service, providing a potential manpower force, including the 44 students in school, of 83 physicians.

Between the date the first recipient became available in 1953 and April, 1969, 108 loan recipients have given service to North Carolina for a total of 664 years of practice, or an average of 6.1 years each. Sixty-nine (69) physicians furnished service to 68 rural communities in 51 counties. The counties are located as follows: There were 21 Piedmont counties with 28 physicians; there were 17 Eastern counties with 24 physicians and 13 Western counties with 18 physicians. The remaining 39 served in mental health facilities throughout the State.

Two (2) recipients are sole practitioners in two of the seven counties having only one physician — Jones County with a population of 11,416 and Pamlico with a population of 9,536.

Avery County in 1940 was rated as one of the 29 most medically disadvantaged counties in North Carolina. By 1968, the county had a physician-population ratio of 1 to 1,336, which was better than the State average of 1 to 1,672. The Medical Care Commission approved educational loans to train three of the physicians then practicing in Avery County.

To staff the only medical facility on the Outer Banks, a loan recipient agreed to practice there as soon as the clinic in Hatteras was completed in 1965. Dare County has an average year-around population of 3,047 to each physician.

Eleven (11) percent of the 120 non-white practicing physicians in North Carolina received Commission loans to finance their medical education. Six (6) of these fulfilled service obligations in counties where they were the only non-white physician; namely, Davidson, Anson, Northampton, Franklin, Person and Wayne.

Of the loan recipients attending the State's three medical schools, graduates remained in the State (not necessarily in rural areas) to practice in accordance with their agreements at the following retention rate: Duke University, 87.5%; Bowman Gray School of Medicine, 61.1%; the University of North Carolina, 55.3%. Although the retention of University of North Carolina medical graduates was at a lower rate, those who did stay in the State were more oriented to service in areas where the need for practitioners was more critical. Bowman Gray was second and Duke third.

Some physicians, after having completed the agreed-upon practice chose to leave the rural communities, but of these, they all moved to other North Carolina towns or returned to residency programs. An analysis of the size of the communities that lost practitioners tends to indicate that the size of the community of residence did not affect the physicians' decisions. For the 69 physicians providing medical service to the rural areas, the average community size was 1,650. The physicians who later discontinued their practice in the initial community moved to communities with an average population of

1,742. As stated previously, in the early years of the program, recipients, as a rule, did not complete a residency before starting practice. Later experience has shown that physicians completing residencies under the program have been more inclined to establish rural practices with more permanency.

Only 22 recipients, approximately 10% of the total receiving loans, failed to provide practice in North Carolina. These repaid their loans with interest.

The following tables summarize the loan program for recipients in all categories:

FINANCIAL STATISTICS

Educational Loan Fund

	1945-63	1945-65	1945-67	1945-69
Total Appropriation	1,200,000.00	1,355,500.00	1,485,500.00	2,085,500.00
Interest Collected on Loans	48,996.26	75,305.00	93,782.57	111,994.62
Total Assets	1,248,996.26	1,430,805.00	1,579,282.57	2,197,494.62
Total Expenditures (Loans)	1,020,523.89	1,318,073.89	1,796,601.90	2,463,941.12
Loans Repaid (Principal)	323,773.96	519,508.51	673,536.27	774,847.23
Loans Cancelled by Satisfactory Service	28,417.00	69,414.85	251,978.68	447,812.24
Total Loans Outstanding (Notes Receivable)	668,332.93	729,150.53	871,086.95	1,241,281.65
Cash Balance	552,246.33	632,239.62	456,216.94	508,400.73
Less: Encumbrances to Complete Education of Students Already Approved	191,358.00	172,033.00	309,676.00	408,333.32
Unencumbered Balance for Financing New Loan Applications	360,888.33	460,206.62	146,540.94	100,067.41
	June 30, 1963	June 30, 1965	June 30, 1967	June 30, 1969
Delinquency Percentage[1]	1.8%	1.2%	.9%	.4%

[1] Active accounts submitted to the Attorney General's Office for collection when the Medical Care Commission is unsuccessful in its negotiations with the recipients and sureties to their notes.

STATUS OF RECIPIENTS WHO HAVE COMPLETED PRESCRIBED TRAINING[1]

Educational Loan Program

Category	1945-June 30, 1963		1945-June 30, 1965		1945-June 30, 1967		1945-June 30, 1969	
	Number of Recipients	Percentage of Total Available	Number of Recipients	Percentage of Total Available	Number of Recipients	Percentage of Total Available	Number of Recipients	Percentage of Total Available
In Practice	59	38.8	71	31.5	96	28.3	149	28.9
Completed Practice	57	37.5	97	43.1	146	43.0	237	45.9
Unable to Practice in Accordance with Loan Agreement	36	23.7	57	25.3	97	28.7	130	25.2
TOTAL	152	100.0	225	99.9	339	100.0	516	100.0

[1] Includes mandatory military service.

SUMMARY OF APPLICATIONS APPROVED

Educational Loan Program
1945-June 30, 1969

	Clinical Psychology	Dental Hygiene	Dentistry	Dietetics	Medical Record Library Science	Medical Recreation	Medical Technology	Medicine	Nurse Anesthesia	Nursing	Optometry	Pharmacy	Physical Therapy	Social Work	Grand Total		Increase or Decrease 1945-69 over 1945-67	
															June 30 1969	June 30 1967	Number of Recipients	%
Total Number of Students Approved	12	6	133	1	5	1	53	226	74	321	3	56	19	54	964	641	323	+ 50.4
In Practice	3	1	16	---	1	---	13	12	35	57	---	4	3	4	149	96	53	+ 55.2
Completed Practice Obligation	2	---	36	---	3	1	20	69	5	58	---	6	2	35	237	146	91	+ 62.3
Enrolled in School	3	4	43	---	1	---	13	31	25	129	2	18	6	3	278	193	85	+ 44.0
Academic Failures	---	---	5	---	---	---	2	4	---	8	1	10	---	---	30	28	2	+ 7.0
Withdrew from School and/or Program	1	1	4	---	---	---	1	9	4	21	---	6	2	5	54	39	15	+ 38.5
Deferred Status	2	---	11	1	---	---	1	51	1	7	---	8	4	---	86	42	44	+104.8
Failed to Comply with Practice Obligation	1	---	18	---	---	---	3	50	4	41	---	4	2	7	130	97	33	+ 34.0

New Students Approved:															Total
1967-69 Biennium	6	6	26	0	2	0	25	27	27	156	2	26	13	11	325
1965-67 Biennium	5	0	31	1	3	1	21	25	20	93	1	13	6	10	230
Increase or Decrease over 1965-67 Biennium:															
Number of Recipients	1	6	- 5	- 1	- 1	- 1	4	2	7	63	1	13	7	1	95
Percentage	20	100	-16.1	-100	-33.3	-100	19.0	8.0	35.0	67.7	100	100	116.6	10.0	41.3

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